Vaucluse Gardens Residential Care

"KARINGAL"

QUEEN VICTORIA HOME

Helping People

OneCare

School of Nursing & Midwifery

UTAS

SNM Aged Care REPORT No.3

BUILDING CONNECTIONS in AGED CARE

Developing support structures for student nurses on placement in residential care:

REPORT on STAGE TWO

Australian Government

Department of Health and Ageing

Building Connections in Aged Care

Developing Support Structures for Student Nurses on Placement in Residential Care

Stage 2 Report

SNM Aged Care Report No. 3

Andrew Robinson, Katrina Cubit, Louise Venter, Linda Jongeling, Brett Menzies, Matthew Fassett, Carey Mather, Sharon Andrews

August 2004

© School of Nursing & Midwifery, University of Tasmania, 2004.

Robinson, A., Cubit, K., Venter, L., Jongeling, L., Menzies, B., Fassett, M., Mather, C. & Andrews, S. (2004). Building Connections in Aged Care: Developing Support Structures for Student Nurses on Placement in Residential Care — Stage 2 Report. Hobart, Tasmania, School of Nursing and Midwifery, University of Tasmania.

August 2004

ISBN: 1 86295 203 5

Correspondence: Dr Andrew Robinson, School of Nursing & Midwifery, Private Bag 121, Hobart, Tasmania, Australia 7001

Stage 2 Project Team

Andrew Robinson	RN, RM, BASANC(ed), MN, PhD Chief Investigator, Senior Lecturer, University of Tasmania
Louise Venter	RN, BSocSci Hons (Nursing Education), MSocSci (Nursing) Co–Investigator, Practice Strand Co–ordinator, Lecturer, University of Tasmania
Katrina Cubit	RN, BN (Hons) Project Manager, Junior Research Fellow, University of Tasmania
Linda Jongeling	RN, BN (Hons) Research Assistant, University of Tasmania
Brett Menzies	RN, BN (Hons) Research Assistant, University of Tasmania
Matthew Fassett	BInfoSys (Hons) Research Assistant, University of Tasmania
Carey Mather	RN, BSc, PgradDip (Hlth Prom) MPH Research Assistant, University of Tasmania
Sharon Andrews	RN, BN (Hons) Research Assistant, University of Tasmania
Caroline Gray	Administrative Assistant, University of Tasmania
Nick Barnard	IT Support, SNM, University of Tasmania

Acknowledgments

This project would not have been possible without the generous support of:

- The Commonwealth Department of Health and Ageing who provided funding for the project.
- Karingal Home for the Aged, The Manor Nursing Home, Mount St Vincent's Nursing Home, Presbyterian Homes Launceston, Queen Victoria Home for the Aged and Vaucluse Gardens Lodge for enthusiastically embracing the project and providing infrastructure support to facilitate the participation of both students and nurses.
- The Steering Committee members for giving their time and input: Mary Binks, Yvonne Kromkamp, Bronwyn Francis, Di McIntee, Julie Dyson, Jo Jones, Pam Pattison, Mary Clear, Yvonne Webber, Julie Crack, Linda Noonan, Linda Jongeling, Rosalind Bull & Anthony Speed.
- The School of Nursing & Midwifery for providing the infrastructure and additional staff time to make the conduct of the project possible.
- Professor Gerry Farrell and Ms Denise Fassett of the School of Nursing & Midwifery for their active support of the project.
- The students and preceptors who so willingly gave of their time and enthusiasm to make this project possible.
- The residents of the six residential aged care facilities for their time and patience in having the students work with them.

Table of Contents

Table of figures and tables

Glossary

- CACNSS Commonwealth Aged Care Nursing Scholarship Scheme
- DON Director of Nursing
- PCA Personal Care Assistants
- ECA Extended Care Attendant (equivalent to PCA)
- EN Enrolled Nurse
- FTP File Transfer Protocol
- PC Personal Carer (equivalent to PCA)
- RACF Residential Aged Care Facility
- RN Registered Nurse
- SNM School of Nursing & Midwifery
- VET Vocational Education and Training Sector
- RCS Resident Classification Scale

Executive Summary

Background

While the aged care industry is a major employer in the Australian economy (Hogan 2004), there are longstanding concerns regarding the recruitment and retention of registered nurses (RNs) into the sector. In Tasmania the situation has been exasperated by the historically limited engagement of undergraduate nursing students in residential aged care facilities (RACFs). Moreover, anecdotal evidence suggests that earlier attempts to place student nurses in aged care only serves to reinforce their ageist attitudes and a resolve among students not to choose aged care as a career option.

To address these concerns, in 2001 the School of Nursing and Midwifery (SNM), University of Tasmania formed a partnership with two aged care industry partners, the Park Group and Masonic Homes Launceston, to test the potential for re-introducing second-year nursing students into RACFs. This initiative resulted in the project 'Making Connections in Aged Care' (Robinson et al. 2002). As the first expression of collaboration between the School and aged care industry in Tasmania, the project aimed to facilitate a positive experience for second-year undergraduate nursing students on clinical placement in aged care.

Following the success of the 'Making Connections in Aged Care' the School received funding from the Australian Government Department of Health and Ageing (DoHA) to further develop the project in other aged care contexts, as a part of the CACNSS program. This project became 'Building Connections in Aged Care'. The intent was to test the approach used in "Making Connections" in other RACFs which, unlike the Park Group and Masonic Homes Launceston, had limited prior involvement with the university sector and were in effect green field locations more representative of residential aged care facilities in general.

The overarching aim of Building Connections is to develop quality clinical placements in aged care. Specific aims include:

1. developing sustainable support structures for undergraduate nursing students in practice in residential aged care, including CACNSS scholarship holders;
2. promoting aged care as an attractive working environment for student nurses and to facilitate their interest in working in the sector;
3. facilitating professional development among aged care nurses to increase their capacity to effectively support undergraduate students in aged care;
4. building capacity among the aged care nursing workforce in the participating RACFs to develop them as key sites for teaching and research in aged care in Tasmania.

The project was planned to proceed over three stages between September 2003 and April 2005. Leveraging off its well-established networks within the aged care sector, the School negotiated with six aged care industry partners, located in the north, north-west and south of Tasmania, to take part in the project. These included Karingal Home for the Aged, The Manor Nursing Home, Mount St Vincent's Nursing Home, Presbyterian Homes Launceston, Queen Victoria Home for the Aged and Vaucluse Gardens Lodge.

Additionally, the industry partners agreed to provide funding to support Stage 3 of the project, and the School of Nursing and Midwifery agreed to contribute equivalent in-kind support. While Stages 1 and 2 of the project were structured to corresponded with two cohorts of second-year

student nurses (n=40) involvement in a three-week clinical practicum in the RACFs, it was agreed the focus of Stage 3 would be determined at the completion of Stage 2.

Research approach

Following the 'Making Connections' study, this project also utilises a Fourth Generation Evaluation method. This method has a strong focus on promoting the research participants' involvement as collaborators in the research process. To implement the method, groups of students and nurse preceptors who support them in practice, meet in separate, weekly parallel group discussions throughout the students' three-week practicum. This involves the formation of three preceptor groups and three students groups, associated with the participating RACFs in each of the three regions of the State. In each region two RACFs are paired with both students and preceptors from the pair-facilities coming together to meet in a preceptor group and a student group. A feedback loop between the respective preceptor and student groups in each region was facilitated by members of the research team to enhance communication and problem solving. Additionally, preceptors attend further meetings for the purposes of planning and evaluation. It is important to note that participation required some travel as the paired RACFs are located, on average, 20 minutes drive from each other. Therefore, in each region meetings were held in alternate facilities on a weekly basis.

The report of Stage 2 of the Building Connections in Aged Care project

In Stage 1, the primary intent of the research was to scope the issues which impacted on teaching and learning for student nurses on placement in residential care contexts, as well as the capacity of the involved RACFs to support an educative agenda. In Stage 2 the focus was on implementing the key recommendations made in the Stage 1 report and to investigate possibilities for developing quality clinical placements in aged care.

Similar to Stage 1, in Stage 2 of the project the researchers had an ongoing and intense involvement with students and nurse preceptors in the context of the research meetings — five preceptor and three student meetings (n=24) in each region. The collaborative interactive approach implicit in the Fourth Generation Evaluation methodology, supported the participants' sense of ownership and their desire to flesh out and address the issues raised. Consequently, like Stage 1, the findings presented in the Stage 2 report provide a unique insight into the operation of RACFs not previously documented in the literature.

The interest in this project in developing quality clinical placements in aged care as a strategy to promote recruitment into the sector has never been more relevant. There is no doubt that problems with recruitment and retention of nurses in aged care are ongoing. As the National Review of Nursing Education 2002 (Department of Education; Science and Training and Department of Health and Ageing 2002a) suggest, this as 'the most significant issue' related to the aged care workforce.

Similarly, concerns with recruitment and retention in the sector underpin the DoHA attempts to promote aged care to student nurses as a viable career option. This is apparent not only in the CACNSS program, but also in efforts to promote aged care among undergraduate students through funding the development of a principles paper which outlines 'desirable aged care content for inclusion in undergraduate nursing curricula' (Queensland University of Technology 2004).

Moreover, the development of partnerships between the aged care industry and universities, such as that flourishing in the context of the Building Connections project, have increasing relevance to a contemporary aged care environment. The recently released Review of Pricing

Arrangements in Residential Aged Care (Hogan 2004) argues that problems with recruitment and retention in aged care need to be addressed through the development of an evidence base in aged care and new educational and training curricula. The review also suggests that aged care providers should take a lead role to 'grow' their own staff through the use of innovative educational and training avenues.

This statement reflects the intent of the Building Connections project which employs an innovative approach to assist the participating aged care providers to 'grow' their staff. Indeed, the Building Connections project can be seen as a material expression of the intent outlined in the Pricing Review and its calls for closer links between aged care and the university sector (Hogan 2004:285), as the project represents a collaboration between Government, the aged care industry and the tertiary education sector to support the growth in the sector required to meet the ageing of the Australian population

Project steering committee

The project operates under the auspices of a steering committee comprising key stakeholders in the field. Prior to publication, a draft of the Stage 2 report was reviewed and subsequently endorsed by the project steering committee members. They also had significant input into a determination of the recommendations outlined in this report and the direction of Stage 3 of the project.

Report structure

The report comprises eight sections. They include:

1. Section one provides a background to the project;
2. Section two addresses the project methodology;
3. Section three outlines the research design;
4. Section four provides background information and demographic data on the participants and partner RACFs;
5. Section five addresses the Stage 2 findings;
6. Section six outlines a series of recommendations and a detailed discussion of the issues raised in the project; and
7. Section seven Appendices and References.

A précis of the discussion contained in Section six and the 15 project recommendations are outlined below.

Discussion and Recommendations

Recruitment into aged care

Change in student attitude to working in the sector

Given the potential impact on the recruitment and retention, a key focus of this project was to facilitate the development of quality clinical placements in aged care as a strategy to positively influence student attitudes to working in the sector. Consistent with the Stage 1 recommendations, Stage 2 of the project implemented a number of strategies to address problems with the orientation of students to the RACFs and to promote a greater degree of continuity between students and their preceptors. The implementation of these strategies and associated changes had a major impact, which was no more obvious than the positive change in student attitude to working in the sector.

In Stage 1 of the project, which had a focus on scoping the issues that impact on student (n=20) experiences in the RACFs, there was minimal improvement in student attitudes to working in the sector as a consequence of their participation in the project. In this stage the shift in sentiment changed from 50% of students nominating that they would consider working in aged care on entry, to 64% at the completion of the practicum.

In contrast, the Stage 2 findings demonstrate that the implementation of the Stage 1 recommendations had a significant positive impact on students' (n=20) stated career intentions. For example, on commencement **55%** of students indicated they would **possibly not/definitely not** have an interest in working in aged care following graduation. However, at the end of their first week in practice, following orientation to the facilities, **80%** of students indicated a **possible/definite** interest in working in aged care following graduation. Moreover, at the completion of the practicum **90%** of students indicated a **possible/definite** interest in working in aged care following graduation. The evaluation also demonstrated a threefold decrease in the number of students who held definite views that they **would not** work in aged care following graduation.

These findings highlight the effectiveness of the approach utilised in the Building Connections project to bring about a positive shift in student attitude to working in the sector. However, it must also be acknowledged that the Stage 2 student cohort was somewhat different to the cohort involved in Stage 1. The Stage 1 students participated in a three-week hospital practicum prior to working in the RACFs. In contrast, the Stage 2 students had no substantive prior experience in practice.

Given this difference in cohorts, it is important to further investigate if prior experience in an acute hospital has a significant impact in influencing student career intentions. To this end it is appropriate to replicate the project with a third cohort of students to investigate if prior experience in a hospital impacts on student perceptions of aged care and related career intentions.

Recommendation 1

> **That Stage 2 of the project be replicated with a third cohort of students who have prior experience in acute care hospitals, to determine if participation in Stage 3 of the project results in a similar positive shift in attitude with respect to students' intention to work in aged care.**

Evaluating sustainability

A key focus of the Building Connections project is to develop sustainable support structures for student nurses on placement in RACFs. Consequently, it is imperative to assess the sustainability of improvement, demonstrated in Stage 2, as a result of the six RACFs' involvement in the project. The conduct of an evaluation with second year nursing students (n=40) on placement within the six RACFs, during Semesters 1 and 2 of the 2005 academic year, following the completion of this project, will provide further evidence of the sustainability the approach employed in Building Connections to develop quality clinical placements in aged care.

Recommendation 2

> **That a follow up evaluation be conducted across Semesters 1 and 2 of the 2005 academic year, with second-year nursing students (n=40) on placement in the participating RACFs to determine if the students' attitudinal change to working in aged care following graduation is sustained.**

Evaluating impact

To further evaluate the impact of the research, an evaluation should be conducted with students who undertake clinical placements in RACFs that have **not** been involved in the Building Connections project. This evaluation will enable a determination to be made of any change in the students' attitude to working in aged care as a result of this experience. The findings of this evaluation can then be compared with the evaluation conducted in the participating RACFs in 2005 (outlined above in Recommendation 2), and provide further evidence of any impact on student attitudes/experience as a consequence of the RACFs involvement in the research.

Recommendation 3

> **That evaluations be conducted across Semesters 1 and 2 of the 2005 academic year, with student nurses (n=40—60) on clinical placements in RACFs not previously involved in the research. This will allow a determination of any change in their attitude to working in aged care following graduation.**

Evaluating transferability

It is probable the findings of the Building Connections project have high-level transferability across a range of residential aged care contexts. The involved facilities are generally representative of RACFs because they include private and charitable providers, are located in both rural and urban environments, vary in size and the services they offer, and have had limited prior engagement with the university sector. Similarly, like many aged care contexts, the RACFs involved in this project have three to four undergraduate nursing students on clinical placement at any one time.

Nevertheless, it must be acknowledged that the transferability of the strategies developed to facilitate quality clinical placements in aged care to other RACFs both within rural and remote regions of Tasmania, or indeed in other Australian States has yet to be tested. With respect to the latter, because the project has been conducted in only one state of Australia, the impact that regional variations may have on the applicability of this approach in developing

quality clinical placements in aged care need to be evaluated. This evaluation is best undertaken in collaboration with other schools of nursing interstate.

Therefore it is essential to expand the project into other RACFs to further test the transferability of this approach in facilitating a positive shift in students' attitude to working in the sector. Expanding the breadth of the research will also facilitate further refinement of this approach to developing quality clinical placements in aged care and allow a more accurate evaluation of its applicability across a range of contexts.

Recommendation 4

> **That the Building Connections project be replicated in other areas of Tasmania to further investigate the applicability of this approach to developing quality clinical placements in aged care.**

Recommendation 5

> **That the School of Nursing and Midwifery, University of Tasmania collaborate with other Schools of Nursing to replicate the Building Connections project in at least two other Australian states to further investigate the applicability of this approach to developing quality clinical placements in aged care.**

Other issues impacting on recruitment

It must be recognised that while developing quality clinical placements in aged care will have a significant impact on student attitudes to working in residential aged care, it is not a panacea. A number of other issues also have a significant impact on student decision making. For example, the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:223) notes the 'disparities of pay for aged care nurses compared to acute care nurses can act as an obstacle to recruitment and retention of skilled staff in the sector'. Similarly, it is noteworthy that in both the context of the research group discussions and the final project evaluation, the students involved in Stage 2 of Building Connections identified disparities in salary rates between aged care and other areas of nursing as a significant disincentive to working in the sector.

Furthermore, many students involved in Stage 2 found the responsibilities associated with being an RN in aged care somewhat overwhelming. This finding mirrors that reported in Stage 1 of this project, as well as the Making Connections project (Robinson et al. 2002). It further reinforces the contention that if the students do not perceive the role of a registered nurse in aged care to be congruent with their perception of their role following graduation, this raises a fundamental obstacle to encouraging new graduates to work in the sector. It is noteworthy that this issue is raised by yet another group of students. This finding further highlights the importance of funding a national project, recommended in the Stage 1 report, to examine the role of the registered nurse in aged care with a specific focus on his/her involvement in the provision of nursing care to residents and the supervision of unregulated workers.

RACF orientation for students

The Stage 2 findings illustrate the importance of nursing students receiving a thorough and well-planned orientation into RACFs, as an important component to establishing quality clinical placements in aged care. The students' comments clearly indicate the significance associated with feeling welcome in the facilities and the importance of the facility staff being organised and prepared for their arrival. Indeed, an explicitly welcoming attitude is critical to

giving students an impression that their presence is highly valued by RACFs staff. The importance of this is reinforced by the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:224-5), which notes, 'an unsupportive environment [has] often been cited as [a] reason for nurses leaving aged care or not being willing to enter this area of employment'.

With respect to orientation, the findings illustrate that the value of informing all staff regarding the imminent arrival of students cannot be overestimated. Similarly, the importance of comprehensive preparation, as well as an explicitly welcoming approach from RACF staff is evident in the students' change in attitude after just four days in practice outlined previously. The findings also highlight the importance of RACFs and Schools of Nursing working closely in the organization of clinical practicums, if aged care staff are to provide effective induction and orientation processes.

Analysis of the data reveals a three stage process which should be employed if RACFs are to take undergraduate nursing students on clinical placements. The stages are outlined in detail on P. 86 of this report and include (1) the supply of information relating to students, (2) the identification of key stakeholders and formation of a preceptor group and (3) preparation of staff and development of resources. The implementation of these stages can be regarded as the cultural and organisational prerequisites to setting up a quality clinical placements in aged care.

Recommendation 6

To achieve quality clinical placements in aged care, RACFs should implement the three stages of preparation prior to students undertaking clinical placements in aged care, to ensure:

1) **appropriate information regarding students is available within the facilities;**
2) **key stakeholders are recruited to support students; and**
3) **facility staff and resources are appropriately prepared.**

Continuity between students and preceptors

The findings demonstrate that a high level of continuity in the relationship between preceptors and students has multiple benefits and as such should be considered implicit in the development of quality clinical placements in aged care. Interestingly, the preceptors reported that working with a student over time made the role of preceptor more satisfying – a finding also supported by the Making Connections in Aged Care project (Robinson et al. 2002). Furthermore, the findings suggests continuity between student and preceptor enhances the possibilities for building rapport, as well as the preceptors' capacity to assess changes in student competence and confidence, which in turn empowers them to structure appropriate teaching and learning experiences in response. It is also apparent that students appreciate working with preceptors who can make what they consider to be informed decisions regarding progress, and that continuity with preceptors, combined with working in the same area over time, enhances students' capacity to a positive contribution to the care team. In turn, this facilitates their acceptance within the team and the positive nature of their experience.

Developing rosters well in advance and matching individual students with their preceptors is essential if an appropriate level of continuity between student and preceptor is to be achieved. This kind of planning is important in RACFs where most nurses work part time and their rosters are defined by the requirements of shift work. Despite the limitations associated with rosters and part-time work, with forward planing, it is possible to achieve a satisfactory level of continuity between the students and preceptors. What is important to acknowledge is that continuity between the two significantly enhances the overall experience of students and as

such can be considered a core component of quality clinical placements in aged care. This is no more evident in the Stage 2 project, which highlighted that students have a far more positive relationship with their preceptors compared to their colleagues involved in Stage 1.

However, while the findings do indicate the benefits of continuity, the data collection processes employed in Stage 2 of the project did not allow the extent of continuity between students and their preceptors to be accurately quantified. It is important to quantify what level of continuity between preceptors and student is necessary to promote a quality engagement and effective teaching and learning. This will allow the establishment of a benchmark against which RACFs can judge the degree to which they are realising a quality clinical placement for students.

Recommendation 7

In order to develop quality clinical placements in aged care:

1) **RACF staff should develop rosters so students have the opportunity to both work with their preceptors over time;**
2) **rotations through areas in RACFs should be minimised to allow students to gain familiarity with both the context and residents; and**
3) **the rotation of students to different areas of RACFs should be the subject of negotiation between preceptors and students.**

Recommendation 8

The extent of continuity between individual students and their preceptors should be determined in Stage 3 of the project to begin the process of developing a benchmark for continuity in quality clinical placements in aged care.

Student activities & supervision

A key finding of Stage 2 of the project is the significant differences between the six involved RACFs. While this is most obvious in their size, location and staffing profiles, data collected on the activities in which students were involved, and with whom they worked reveals that in the context of aged care placements, students can engage in a very different mix of activities in one facility as compared to another. In part these differences relate to with whom it is the students work. For example, if students spend more time working with PCAs their involvement with residents in activities of daily living greatly increases, reflective of a reality in aged care where PCAs provide most general care to residents. However, there are a number of issues which must be addressed if students are to have a positive experience when working with aged care staff.

Students working with supervised practitioners

In Stage 2 of the project that data revealed that on average students worked either directly or indirectly with PCAs for around 12.5 % of the practicum, and around 17% with ENs. In both these circumstances the regulatory requirements governing nursing mean that students must be supervised by an RN.

While students working with PCAs and ENs may be a reality in aged care, we have little or no information on the strategies RNs employ to ensure adequate supervision, how they monitor students' work, or what activities they undertake to ensure quality teaching and learning outcomes. The lack of information regarding the structures and processes to support the supervision of students in aged care suggest that it is essential to investigate this issue

further. This is especially important given the increasingly administrative and procedurally focused role of RNs working in the sector.

Recommendation 9

> **That the structures and processes employed by aged care nurses to supervise students whilst working either directly or indirectly with PCAs and ENs be investigated as a key focus of Stage 3 of the project.**

Preparing PCAs to work with students

The findings reveal that students can spend up to 25% of their clinical placement in RACFs either directly or indirectly with PCAs, and that as demonstrated in Stage 1 of this project, this can be a less than rewarding experience. Following the Stage 1 recommendations, in Stage 2 of the project a range of strategies were implemented to prepare both students and PCAs to work together. These included meeting with students to discuss the issue of working with PCAs prior to their entry into the facilities, targeting appropriate PCAs to work with students and holding formal and informal meetings with PCAs to discuss issues around working with students.

In Stage 2 of the project implementation of these strategies appears to be effective because the students reported far more positive experiences when working with PCAs than in Stage 1. However, the preparation of PCAs to work with students is an issue that needs further investigation. While the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004) recommends the upgrading of PCA training, it is reasonable to suggest that preparation of PCAs to support students in clinical placements should be integral to this process. Within a contemporary aged care environment this must be an important development given the inevitability that student nurses on placements will work with PCAs in the provision of resident care.

Recommendation 10

> **That consideration be given to investigate strategies to prepare PCAs to support nursing students on placement in RACFs as a component of Certificate III or IV qualification.**

Supervisory tensions for preceptors

The Stage 2 findings reveal that in their role as preceptors, both working with and supervising students, aged care nurses face multiple tensions, not least of which is related to workloads. It is an issue also appreciated by students who made numerous comments that the RN preceptors were extremely busy and often appeared to be overwhelmed by their administrative responsibilities. These findings suggest that the capacity of aged care nurses to effectively supervise students needs further investigation in Stage 3 of the project.

Recommendation 11

> **That Stage 3 of the Building Connections in Aged Care project investigate tensions between the nurses' role as preceptors in supervising and teaching students and their role in ensuring the provision of quality resident care.**

Student involvement with residents

The findings of Stage 2 demonstrate that students have varied interactions with residents. While some students struggled with the unfamiliarity of working with older people others

appeared comfortable and at ease. It is also apparent that the reality of aged care and the situation of residents has a significant impact on students' perceptions of aged care and more than likely influences their decision making with respect to working in the sector following graduation. These issues warrant further investigation in Stage 3 of the project, to develop a better understanding of resident involvement with students and how this impacts on the students' experience of aged care and their perceptions of the sector.

Recommendation 12

That Stage 3 of the Building Connections in Aged Care project investigate resident involvement with students and how this impacts on the students' experience of aged care and their perceptions of the sector.

Involvement in the physical assessment activities

While Stage 2 data revealed that students were primarily involved in medication management (22.7%), hygiene activities (13.1%) and activities of daily living (11.4%), no data was collected on their involvement in the physical assessment of residents. The lack of reference to physical assessment needs to be addressed because this is a core activity in RACFs, and a key function of aged care nurses, as it directly informs not only the provision of care, but also the Resident Classification Scale (RCS) documentation and facility accreditation. In Stage 3 of the project it is important to collect data on students' involvement in the physical assessment of residents, as well as who it is that supervises and instructs students in this activity.

Recommendation 13

That data be collected in Stage 3 of the project to determine the extent of students' involvement in the physical assessment of residents and who it is that supervises and instructs students in this activity.

Differences between high and low care

The Stage 2 findings reveal limited information on the differences in student experiences when they work in 'high care' areas as opposed to 'low care' areas. Similarly, the impact on RN supervisory practices when students are placed in high care environment as opposed to low care environments is also unknown.

Recommendation 14

That data be collected in Stage 3 of the project on the activities undertaken by students in high care and low care in order to better understand how this impacts on their clinical placements and the effects for RN supervisory practices.

Building capacity among aged care nurses

A key focus of the Building Connections project is to build capacity among aged care nurses, particularly in relation to their role and function in working as preceptors with students. The Stage 2 findings reveal that participation in the research had a very positive impact on the preceptors' knowledge and confidence. They also demonstrate that students found the nurses to be highly effective in their role as preceptors. However, it is imperative that RACF staff have an ongoing engagement in developing their knowledge, understanding and practice as nurses.

The findings of both Stage 1 and Stage 2 of Building Connections demonstrate that the presence of the students provides a critical stimuli for aged care nurses to become more active learners and to critically reflect on their practice. However, it must also be appreciated that students alone will not provide the impetus for such developments. The teachers, in this case aged care nurses, must also be professionally engaged and receptive to the challenges that students inevitably raise.

A key finding, also evident in Stage 1 of the project, highlights the importance of aged care nurses having an opportunity to meet to discuss practice issues, both within their facilities and with colleagues from other RACFs. In this sense, participation in the research functioned not only as a capacity building exercise, but also as an effective strategy to break down the nurses' professional isolation. Such findings demonstrate the previously mentioned benefits associated with collaborations between residential aged care and university sectors, a development championed in the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:285), which called for closer links between the two sectors.

However, it is important to recognise that the benefits of such developments are cumulative and that nurses' involvement in these processes should be ongoing. This is especially important in aged care where, as Stage 1 findings highlight, aged care nurses work in relative isolation in a context characterised by a limited professional engagement or networks into the wider aged care sector. As stated previously, the Pricing Review (Hogan 2004) raises this concern when it notes that aged care nurses lack educational opportunities and it puts the view that aged care providers should 'grow' their own staff through the use of innovative educational and training avenues. In the context of the CACNSS program, it is arguable that additional funding should also be provided to augment the availability of scholarships, in order to create linkages with aged care systems to support the aged care workforce to take up educational and professional development opportunities within the sector in order to build capacity to support scholarship holders appropriately.

Recommendation 15

> **That Australian Government funding be applied to create linkages with aged care systems to support the aged care workforce to take up educational opportunities within the sector to build capacity to support CACNSS holders and thereby develop quality clinical placements in aged care.**

Final Comment

The Building Connections project is located within an industry which faces significant challenges. The ongoing problems surrounding recruitment and retention of appropriately qualified nurses; the part-time nature of the workforce; the context of limited professional engagement within which aged care nurses work and the lack of an evidence base for training and curricula in aged care serves to create an environment where, in the past undergraduate nursing students have found themselves grappling with the realities of aged care nursing.

Despite such challenges, this research has successfully bought about change not only in students' attitudes towards working in an aged care environment but also in preceptors' approach towards preparing for and working with undergraduate students. As a result of collaboration between the RACFs and the Tasmanian SNM a cohesive infrastructure of support was established to facilitate quality clinical placements for students. Integral factors in this infrastructure were, adequate preparation of RACF staff prior to student arrival, comprehensive student orientation to the RACF and a high level of continuity between students, their preceptors and work areas. The ability of this research to encourage students to reconsider and challenge their understandings of aged care nursing is a testament to the

success of the fourth generation evaluation approach and ultimately the collaborative effort adopted between the six RACFs and the university.

The collaborative approach between the Tasmanian SNM and the RACFs, has demonstrated that the calls for closer links between aged care and university sectors (Hogan, 2004:285) is not only possible, but may be highly successful in forging a future where undergraduate students are more likely to consider aged care as an attractive career option. Beyond the six RACFs involved in this research, it is essential that other industry leaders be cognizant of the benefits of tertiary collaboration, and play a role in ensuring quality clinical placements are developed and consistent across the industry. From this perspective, it is imperative that this research be extended to ensure transferability and sustainability and consequently attract both state and federal attention to develop this evidence base within aged care.

1. Background

Precursors to the 'Building Connections in Aged Care' project

While the aged care industry is a major employer in the Australian economy (Hogan 2004), there are longstanding concerns regarding the recruitment and retention of registered nurses (RNs) into the sector. In Tasmania the situation has been aggravated by the historically limited engagement of undergraduate nursing students in residential aged care facilities (RACFs). As outlined in previous reports conducted by this research team (Robinson et al. 2002; Robinson et al. 2004), this has undermined the ability of providers to attract new graduates and frustrated the professional development of aged care nurses. Moreover, anecdotal evidence suggests that earlier attempts to place student nurses in residential aged care only serves to reinforce their ageist attitudes and a resolve among students not to choose aged care as a career option.

In the 1980s, the Tasmanian School of Nursing placed first-year student nurses in residential aged care facilities to develop their skills in assisting older people to undertake 'activities of daily living'. However, as the structure of the Bachelor of Nursing course changed, aged care facilities were no longer utilised. In 2001, the School collaborated with two aged care industry partners, the Park Group and Masonic Homes Launceston, to test the potential for re-introducing second-year nursing students into RACFs. This initiative resulted in the project 'Making Connections in Aged Care' (Robinson et al. 2002) which was funded by the two industry partners and the University of Tasmania. As the first expression of collaboration between the School of Nursing and aged care industry in Tasmania, the project aimed to facilitate a positive experience for second-year undergraduate nursing students on placement in aged care. Taking action to address students' negative experiences of aged care was seen as critical to promoting the sector as a viable work site for new graduates. It was also seen as a key strategy to facilitate the professional development of nurses already working in the sector.

The Making Connections project utilised an innovative Fourth Generation Evaluation method (Guba and Lincoln 1989) and involved four cohorts of student nurses (n=26) and two cohorts of registered nurse (RN) preceptors (n=17), who supported the students during their clinical placements in the RACFs. The project achieved significant outcomes, most notable being an important positive change in student career intentions, with respect to working in residential aged care following graduation. On entry 64% of students indicated they **would not** consider aged care as a future employment, while at completion, 92% indicated they **would** consider aged care as a future employment. Similarly, the RN preceptors reported that participation in the research, combined with working with students, provoked their involvement in professional development activities. Furthermore, positive reports from subsequent groups of students on placement in the facilities indicated a high level of sustainability for this approach to bringing about improvement.

Establishing the 'Building Connections in Aged Care' project

The success of the 'Making Connections in Aged Care' led the Tasmanian School of Nursing[1] to seek funding from the Australian Government Department of Health and Ageing (DoHA) to further explore the applicability of the strategies implemented in the project. The intent was to test the approach used in Making Connections in other RACFs which had limited prior involvement with the university sector. This was important because the Making Connections industry partners had a significant prior involvement with the School of Nursing and Midwifery, including involvement in the Bachelor of Nursing (Hons) program. The positive results achieved were in part attributable to this engagement. In contrast, it was decided that those RACFs involved in Stage I of the Building Connections project should not have significant prior engagement with the School. In this sense aim was to implement the project in green field locations more representative of residential aged care facilities in general.

Following the submission of a tender, the School received funding as a part of the Commonwealth Aged Care Nursing Scholarship Support Systems (CACNSS) program, to conduct the 'Building Connections in Aged Care' project over three Stages. While the overarching aim of the project is to develop quality clinical placements in aged care, specific aims include:

1. developing sustainable support structures for undergraduate nursing students in practice within residential aged care, including Commonwealth Aged Care Nursing Scholarship Scheme (CACNSS) scholarship holders;
2. promoting aged care as an attractive working environment for student nurses and to facilitate their interest in working in the sector;
3. facilitating professional development among aged care nurses to increase their capacity to effectively support undergraduate students in aged care;
4. building capacity among the aged care nursing workforce in the participating RACFs to develop them as key sites for teaching and research in aged care in Tasmania.

The first two stages of the project were structured to correspond with the participation of two cohorts of second-year student nurses in a three-week clinical placement in the RACFs. While a third stage was planned, its focus was to be determined at the completion of Stage 2.

Leveraging off its well-established networks within the aged care sector, the (SNM) negotiated with a number of aged care providers to participate in the project. In mid-2003 meetings were held with key staff in six targeted RACFs, where the project investigators outlined the proposed research. This included a proposal that the industry partners provide additional funding to support the conduct of Stage 3. Six RACFs, located in the north-west, north and south of Tasmania, subsequently agreed to participate. These included Karingal Home for the Aged, The Manor Nursing Home, Mount St Vincent's Nursing Home, Presbyterian Homes Launceston, Queen Victoria Home for the Aged and Vaucluse Gardens Lodge.

In July–August 2003 key stakeholders were subsequently invited to join a project Steering Committee (see Section 4 for membership of the Steering Committee), which met for the first time in August 2003. Stage 1 of the project commenced in September 2003 and involved 30 registered and enrolled nurse preceptors and 20 second-year nursing students who participated in a three-week clinical placement in the six RACFs. Stage 1 fieldwork, which had a primary focus on scoping the issues that impact on student experiences and the capacity of the involved RACFs to support an educative agenda, was completed in mid-October 2003. The project Steering Committee subsequently met in February 2004 to consider a draft report of

[1] Since renamed the School of Nursing and Midwifery (SNM), University of Tasmania.

this stage, prepared by the research team. At this meeting it was evident that many of the Steering Committee members found the report findings somewhat confronting, but at the same time acknowledged that it accurately represented the issues facing the RACFs in their efforts to support student placements. Within the committee there was a positive resolve to continue the project into Stage 2 and this was no more emphatic than among the Directors of Nursing representing the six participating RACFs. Subsequently, Steering Committee members collaborated with the research team to develop a series of recommendations to be implemented for Stage 2 of the project. The report of Stage 1 was then submitted to DoHA in March 2004 (see Robinson et al*.,* 2004).

Setting up Stage 2 of the Building Connections Project

In March 2004 all preceptors who participated in Stage 1 were sent a copy of the corresponding report. In April 2004 the project investigators attended meetings in each of the six RACFs to discuss the Stage 1 report findings with the preceptors and consider possibilities for implementing relevant recommendations made in the report.

With the exception of one facility, which had experienced a significant change in personnel, all the meetings were well attended. The reaction of the preceptors ranged from interest in how to move forward, to anger. It was evident that some preceptors' felt that they had worked very hard to support students and that the Stage 1 report was in part, a 'slap in the face'. At the same time there was acknowledgement among all the groups that the Stage 1 report provided a unique insight into the perceptions, understandings and experiences of students and as such did reflect an accurate representation of the issues. The members of all the preceptor groups indicated they were keen to participate in Stage 2, and began the process of considering possibilities for implementing the relevant recommendations in their respective facilities at the meetings.

Subsequently, Stage 2 commenced in May 2004. This Stage of the project had a focus on implementing the key recommendations made in the Stage 1 report and to investigate possibilities for developing quality clinical placements in aged care. A draft report addressing the findings of Stage 2 was discussed at the third Steering Committee meeting held in August 2004, prior to the submission to the Commonwealth of the Stage 2 report in late August. At this meeting steering committee members raised a number of issues, which greatly informed the recommendations presented in this report.

Locating 'Building Connections' project within aged care

While this report addresses the findings from Stage 2 of the 'Building Connections in Aged Care', it is important to acknowledge that the project takes place within an industry that has been subject to a number of significant reviews, which will provide a framework for its development over the coming years.

Concerns with the operation of the residential aged care industry have prompted the Australian Government to initiate a number of recent reviews into the sector. These include reviews into the IT capacity within aged care (Australian Department of Health and Ageing 2003), the use of the Resident Classification Scale (RCS) in the determination of resident dependency and subsequent facility funding (Commonwealth Department of Health and Ageing 2003) and a review of the aged care work force (Healy and Richardson 2003). However, by far the most significant and influential review of the industry has been the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004).

While this Pricing Review addresses a wide spectrum of issues in need of consideration in aged care, it offers a number of observations pertinent to the Building Connections project,

none more relevant than the aged care workforce. For example, the Review notes that the environment in which student nurses often find themselves when on placement in the residential care sector has experienced a decline in the number of people employed, between 1995–96 and 1999–2000, while the number of people cared for in the sector has increased. At the same time the Review also notes an increase in the number of employees in 'the accommodation for the aged sector (low care)', reflecting the impact of ageing in place (Hogan 2004).

Of significance, statistics from the Australian Institute of Health and Welfare demonstrate that since 1997 the number of RNs employed in the sector has been steadily decreasing, with at least 60% being employed on a part-time basis (AIHW 2003b). However, the workforce study conducted by the National Institute of Labour Studies (Richardson and Martin 2004), referred to previously, provides a detailed insight into the current state of the aged care workforce. It reveals that:

- the aged care workforce primarily employs part-time and casual staff where:
  - the most common form of employment is permanent part-time, accounting for two-thirds of workers,
  - casual staff constitute 20% of the workforce;
  - only 11% of workers in aged care are permanent full-time;
- the largest section of the aged care workforce is made up of Personal Care Assistants (PCAs), at 57%;
- other staff include Registered Nurses (22%), Enrolled Nurses (13%), and allied health personnel (8%); and
- 94% of the direct care workforce is women.

With respect to employment status of aged care staff, Section 3 of this report reveals that these figures are similar to those of the six RACFs participating in the Building Connections in Aged Care project.

Who provides care to residents has also become an important issue in the sector. In part this is associated with the increase in Personal Carer Assistants (PCAs) employed in the sector. This is apparent in the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004), which highlights that the role of Registered Nurses and Enrolled Nurses in the provision of 'direct care' to residents has declined, while the proportion of care provided by PCAs has increased significantly. According to the review '[t]hese changes reflect both the growing shortage of nursing staff and the development of more efficient work structures' (Hogan 2004). Such findings are in part supported by in the National Institute of Labour Studies report (Richardson and Martin 2004:29), which notes that 40% of nurses estimate that they spend less than a third of their time on the job in providing direct care for residents. Similarly, the findings of Stage 1 of the Building Connections project (Robinson et al. 2004) highlighted that PCAs provided most of the resident care in the six participating RACFs, with registered nurses having a primary involvement in administrative, supervisory and procedural activities.

While there is a widespread recognition that many facilities have addressed the shortage of appropriately qualified nurses by allocating more duties to unregulated workers, there are concerns that this change 'not only devalues older people and their care but also directly affects the quality of care provided' (Edwards et al. 2003). Indeed, there are concerns that changes to the sector instituted since the introduction of the *Aged Care Act* (1997), reflect the transformation of residential aged care toward a social model of care, which fails to take account of 'the professional health care needs of the acutely sick and complex extreme old person' (Angus and Nay 2003:131). Not surprisingly there are also concerns that with disproportionate increases in the number of unregulated staff has led to increased supervisory responsibilities for RNs (Courtney and Minichiello 1997), and a potential to undermine care standards (Nay et al. 1999). The National Review of Nursing Education 2002 (Department of Education; Science and Training and Department of Health and Ageing 2002b) reports a similar sense of disquiet when it notes an inappropriate skill mix has implications for resident

care, work satisfaction and recruitment and retention, while the Pricing Review notes the need to improve the skill base of PCAs (Hogan 2004:285). With respect to students' involvement in residential aged care, the increasing employment of PCAs in the sector also has implications for teaching and learning. Indeed, Stage 1 of Building Connections revealed that students on placement in RACFs might spend up to 20% of their time working with PCAs.

In part, such concerns relate to the adequacy of PCA training to prepare them to care for residents in RACFs where the level of dependency has steadily increased since the 1990s (AIHW 2003a). While registered nurses must undertake a three year Bachelor of Nursing for registration and Enrolled Nurses typically undertake a Certificate IV, conducted in the Vocational Education and Training (VET) sector, PCAs have traditionally undertaken on-the-job training. However, PCAs are now more frequently expected to undertake between 6 months and 2 years study to obtain a Certificate III in the VET system (Pearson et al. 2001). This change is reflected in the findings of the National Institute of Labour Studies report (Richardson and Martin 2004:29), which notes that PCAs in aged care are very likely to have post-school qualifications with four fifths having a Certificate III in aged care, and 10% having a higher level qualification in aged care.

Other key issues identified in Pricing Review highlight ongoing concerns with shortages of registered nurses and problems with recruitment and retention (Hogan 2004). Similarly, the National Institute of Labour Studies (2004) reports evidence that there are shortages of nurses willing to work in aged care. This is reflected in higher than normal position vacancy rates, difficulties recruiting nurses and that nurses currently employed in aged care are less satisfied than other workers in the sector (Richardson and Martin 2004). This is all the more problematic because the aged care workforce is itself ageing (Hogan, 2004), with approximately a quarter of PCAs and ENs being 50 or over, compared to 46% of Registered Nurses (Richardson and Martin 2004). This profile reflects that of the nurses who participated in Stage 1 of the Building Connections project (Robinson et al. 2004:5). The staffing profiles of six RACFs highlight that 53% of the preceptors in the project were older than 45 years.

There is no doubt that problems with recruitment and retention of nurses in aged care are ongoing, with the National Review of Nursing Education 2002 (Department of Education; Science and Training and Department of Health and Ageing 2002a) citing this as 'the most significant issue' related to the aged care workforce. Concerns with recruitment and retention in the sector underpin the Australian Government Department of Health and Ageing (DoHA) attempts to promote aged care to student nurses as a viable career option, through the Commonwealth Aged Care Nursing Scholarship Support Systems program. DoHA has also funded the development of a principles paper, which outlines 'desirable aged care content for inclusion in undergraduate nursing curricula' in recognition that to promote aged care nursing it is important to address 'inconsistent or hidden content in aged care curricula' as well as its poor image (Queensland University of Technology 2004).

With respect to concerns with recruitment and retention, the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:222-223) identifies numerous barriers to employment in the sector. These include a lack of wage parity, poor working conditions, as well as lack of educational opportunities and career paths for nurses in aged care. The Review also notes that unsupportive work environments, stress associated with staff shortages and high workloads, combined with increases in resident dependency are also seen as contributing to problems with recruitment and retention in the aged care industry.

In terms of addressing problems with recruitment and retention, the Pricing Review offers a number of suggestions. Of particular significance to this project is the identification of a need to develop an evidence base in aged care and new educational and training curricula, as well as providers taking a lead role to 'grow' their own staff through the use of innovative educational and training avenues. Indeed, the Review proffers the view that the 'aged care industry and individual providers take more ownership of the need to develop their workforce' (Hogan 2004:234). The participation of the six aged care providers involved in

this project and their ongoing support of students and nurse preceptors, as well as a commitment to contribute funding to Stage 3 of the research, are consistent with this intent. Moreover, the conduct of the Building Connections project is consistent with the suggestion put forward in the Pricing Review, which argues for 'closer involvement of the industry individually and in partnership arrangements with Government to share the funding of research and development projects for future workforce planning, training and education' in order to ensure the expeditious transfer of evidence into practice (Hogan 2004:234).

As the findings of the Making Connections project (Robinson et al. 2002) and Stage 1 of the Building Connections demonstrate (Robinson et al. 2004), it is essential that aged care staff have access to ongoing professional development opportunities. This is an imperative also supported by the literature. For example, Wade (1999) argues that staff in residential aged care will not deliver high quality person-centred care unless there is an opportunity for ongoing professional development. Similarly, Edwards et al. (2003:108) argue the importance of a 'diversity of educational experience' suggesting the need for staff to be involved in 'a coordinated program of continuing education'. Others argue that links between universities and RACFs enhance their potential as learning environments (Katz et al. 1995; Joy et al. 2000:1044), a position consistent with that preferred in the National Review of Nursing Education 2002 (Department of Education; Science and Training and Department of Health and Ageing 2002a).

Such collaborations are important because there is evidence to suggest that in the right circumstances, aged care facilities can indeed function as learning organisations. This was most evident in the findings of the 'Making Connections in Aged Care' project (Robinson et al. 2002), which illustrated that students can have a positive learning experience and develop their clinical knowledge, skills and competence. Similarly, Chen et al. (2001:57-58) suggest that there are potentially many learning opportunities for students nurses on placement in aged care contexts including 'basic psychomotor skills, communication skills, physical and psychological assessment, safety concerns, patient education and the development of positive attitudes about the ageing process'. Moreover, (Happell and Brooker 2001:17) suggest that the involvement of students in the sector offers clinicians the 'opportunity to present the unique and specialised functions of their role' as aged care nurses. However, at this point in time we have little information about exactly what activities student nurses engage in when on placements in RACFs. This is an issue taken up in Stage 2 of Building Connections and documented in Section 5 of this report.

In conclusion, the above discussion constitutes a brief account of some of the issues confronting the provision of care to older Australian residents in aged care facilities. The intent is to provide an overview of the context where student nurses find themselves when on placement in RACFs and the tensions which frame attempts to facilitate change in order to better support students on clinical placements. As such these issues are highly relevant to this project, which has as a core interest in the promotion of key sites for teaching and research in aged care. It is anticipated that the development of this intellectual capital will act as a mechanism to assist the involved RACFs to become exciting and stimulating places to work and provide best practice care to residents. Such developments are critical if problems with recruitment and retention in the sector are to be addressed and quality clinical placements in aged care are to be developed. In this sense, the Building Connections project can be seen as a material expression of the intent outlined in the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:285) and its calls for closer links between aged care and the university sector. The project represents a collaboration between Government, the aged care industry and the tertiary education sector to support the growth required to meet the ageing of the Australian population.

2. Methodological approach

Fourth Generation Evaluation

The project utilised a 4th generation evaluation methodology (Guba and Lincoln 1989:72-74). This involved the formation of three groups of registered nurse preceptors and three groups of student nurses on clinical placements in the six RACFs. This approach was employed to facilitate communication (McGuiness and Wadsworth 1991) between the students and their preceptors as previous research has demonstrated this process to be very effective in facilitating teaching and learning in practice (Robinson et al. 1999; Robinson et al. 2002).

To implement the method, similar to Stage 1, students and preceptors met in separate, parallel groups on a weekly basis throughout the three–week practicum. Sessional project officers employed by the SNM in Stage 1 again participated in both student and preceptors groups in each RACF and facilitated a feedback loop between the student and preceptor groups on an agreed-to basis. The feedback loop provided anonymity for both parties and a safe mechanism for students and their preceptors to provide critical comment.

As in Stage 1, the nature of the discussions in the research groups were structured according to a series of ground rules that established an environment of trust (Giroux 1988:72). By engaging in reciprocal dialogue the students and preceptors were encouraged to critically reflect on their experiences through the process of story telling. Story telling is a well established educational technique by which habit, ritual and taken-for-granted understandings can be recast as the extra-ordinary and unfamiliar (Epston and White 1992). For example, a preceptor may re-conceptualise his/her role and a student nurse may reconsider his/her work with elderly people in an aged care facility. Ultimately, the possibility for alternative narratives emerges and by implication, possibilities for developing new understandings of teaching and learning in aged care (see Appendix 1 for a more in-depth discussion of this approach).

Data collection

Research meetings

Both preceptor and student research meetings held in each region were audio-taped and transcribed. The transcripts were developed into **research case notes** by the research project officers who facilitated the student and preceptor research groups in each region. The case notes represent a first level analysis of the issues raised. The notes of one meeting were returned to the respective participants prior to the next. The intent was to promote critical reflection on the issues raised and to act as markers of progress.

Student and preceptor evaluations

Prior to the commencement students completed **part one** of the **Students Initial Evaluation Part 1** (Appendix 2). In week one of the practicum the preceptors completed the **RN/EN Initial Evaluation** (Appendix 3) and the students completed the **Student Nurse Initial Evaluation Part 2** (Appendix 4) and the. **Orientation Checklist** (Appendix 5). In week three of the practicum the students completed the **Final Student Evaluation** (Appendix 6) and the **BN Student Survey** (Appendix 7)[2]. In week five the preceptors completed the **Preceptor Final Evaluation** (Appendix 8) and the **BN Preceptor Survey** (Appendix 9).

Supervision and placement activities log

A key aspect of the 'Building Connections' project is to establish what activities student nurses engage in whilst on placement in aged care settings and whom they work with.

During Stage 1 the 'Supervision and Placement Activities Log' (known as the 'log') was trialed for the students to record their level of supervision and activities undertaken. This tool was further developed and implemented in Stage 2. The 'Supervisor Log' used in Stage 1 was reviewed and modified to:

- simplify the research tool;
- increase student compliance in completing the log;
- increase the accuracy;
- increase the quality of the data collected; and
- reduce data entry time.

In Stage 2 the Supervision and Placement Activities Log consisted of three 18 x 11 cell grids (one for each week in clinical practice). Students were asked to complete two cells for each hour of each day for the three-week period. The first cell described the supervision and the second the activity or procedure being undertaken. Students used a key to complete a grid for each hour, of each day, for the three weeks in clinical practice, detailing who supervised each activity undertaken. A coding system provided students with a list and examples of potential activities and procedures as well as supervisors. Provision was made for including additional information.

In Stage 2, 19 students completed the Supervision and Placement Activities Log each day for the three-week period. Logs were collected from students at the final meeting in the third week — held on a Thursday. This precluded the collection of data for the last shift (Friday, week three).

Prior to the commencement of the practicum each participating student was provided with a copy of the 'log' (Appendix 10). The project manager instructed the students on how to complete the 'log'. A case study approach was used to demonstrate the method. An example of a partially completed log was included with the log for future reference. Students were requested to indicate the category of worker they were assigned to, and to indicate the nature of tasks, activities and procedures they undertook for the majority of each hour. This was undertaken for each hour of each day during the practicum. Each cell within the log represented one hour. Working alone or unsupervised work, sick leave and absenteeism

[2] Analysis of student response to this survey will be presented in the Stage 3 report, which will allow a comparison to be made between the three cohorts of students participating in the project. This data will also analysed with respect to the BN Preceptor Survey outlined in Appendix 9 to test for a correlation.

information was also elicited. A coding key was provided to the students as part of the 'log'. This key was developed to facilitate ease of data entry and reduce the potential for coding errors.

Students were provided with a copy of the 'log' at the completion of the induction session. They were encouraged to complete the 'log' after each shift of clinical practice, or where time permitted, during the shift. The 'logs' were collected from the majority of students during the last research meeting. Remaining 'logs' were posted to the project manager or collected by the research assistants.

Data analysis

Qualitative data analysis

Data from each of the research meetings was analysed for themes and issues by the respective project officers according to the issues raised. This analysis formed the basis of the case notes, which were returned to the respective participants prior to each subsequent meeting. At this meeting each team member had the opportunity to make amendments or additions to the notes. This process was adopted as a protocol designed to:

- ensure that the content of the case notes represented an agreed position of discussions that took place during meetings;
- promote a reflective engagement with the issues raised and collaborative theorising among the participants.

In each research meeting much of the initial data took the form of research narratives representing the team members' experiences, feelings, and understandings. Following from Feldman (1995), these narratives were subjected 'to a progressive critical process of reading and theorising ... [and were] analysed for recurring patterns and themes.' As such, the intent was to subject the data to ongoing analysis in the context of the research meetings.

While this process did take place during Stage 2 of the project, at times opportunities for collaborative theorising were undermined by the problems experienced in some groups when the respective research participants did not gain timely access to the case notes (see section on IT Interface).

To assist with the process of data analysis and the development of the case notes, following Stage 1, a series of analytical categories addressing both student and preceptor issues were developed for Stage 2. The categories are outlined in below.

The project officers coded data under additional categories as necessary.

Following this data from the case notes were converted into rich text and entered into NVivo© qualitative software. This facilitated a process of reviewing, re-thinking, reflecting and in-depth analysis (Richards 2002).

Data from all the meetings were coded within NVivo© under the thematic categories developed in the case notes. New codes were developed to represent issues that emerged from the themes as the analysis of the data proceeded. The use of NVivo© assisted in identifying the common themes and issues emerging across all the research groups in Stage 2 of the project. It is these themes and issues that represent the findings presented in section 6.

NVivo© also facilitated the tracking of participants and their comments, which allowed for a far greater differentiation of the differences or similarities between facilities with respect to their preceptors' efforts to facilitate teaching and learning and the students' experience of aged care.

Table 1: Analytical categories for assessing preceptor and student issues

Preceptors	Students
• Orientation strategies • Preceptors — Communication re student information • Students involvement in clinical activities • Preceptors — Students working with PCAs • Preceptors — Efforts to facilitate continuity • Preceptors — Students dealing with dementia • Preceptors — Students dealing with old bodies • Preceptors — Changes in student competence/confidence • Preceptors — Barriers to teaching and learning • Issues in being a preceptor • Preceptors — Professional isolation • Preceptors — IT access issues • Preceptors — Benefits of having students in the facility • Preceptors — Benefits of participation in the research	• Orientation experiences • Students — Staff knowledge of students • Students — Involvement in clinical activities • Students — Working with PCAs • Students — Experience of continuity • Students — Dealing with dementia • Students — Dealing with old bodies • Students — Changes in competence/ confidence • Students — Barriers to teaching and learning • Perceptions of the RN role • Issues in being a student in aged care • Students — IT access issues • Students — Benefits of participation in the research

Quantitative data analysis

Preceptor and student evaluations

All quantitative survey data was analysed using Microsoft Excel™ 2002. A number of survey templates were built using Excel worksheets to capture data such as Likert scales, yes/no responses and demographics. Excel was chosen due to the flexibility the software provides in structuring data tables and its powerful charting options. Each survey was assigned a unique alphanumeric code, which enabled the data to be audited for accuracy and to clarify any ambiguous results. Several methods were employed to ensure the accuracy and integrity of the data including cell validation with pull–down lists, 'checksum' formulas and detailed random audits of surveys.

All surveys were manually keyed into the Excel templates and any non-responses or ambiguous responses were noted in a comments field attached to the relevant cell. Descriptive statistical analysis was performed using available Excel formulas and charts, which were customised.

Supervision and placement activities log

The data from the 'log' was input, cleaned and manipulated using SPSS™ version 11.5. New variables were coded during data entry to reflect attendance at research meetings with university staff and meal breaks, absenteeism and sick leave. The coding manual was altered accordingly to match the final survey instrument. Electronic data was password protected and this information was only accessible to the investigators. All paper-based records were stored at the SNM in a locked cabinet within a secure site.

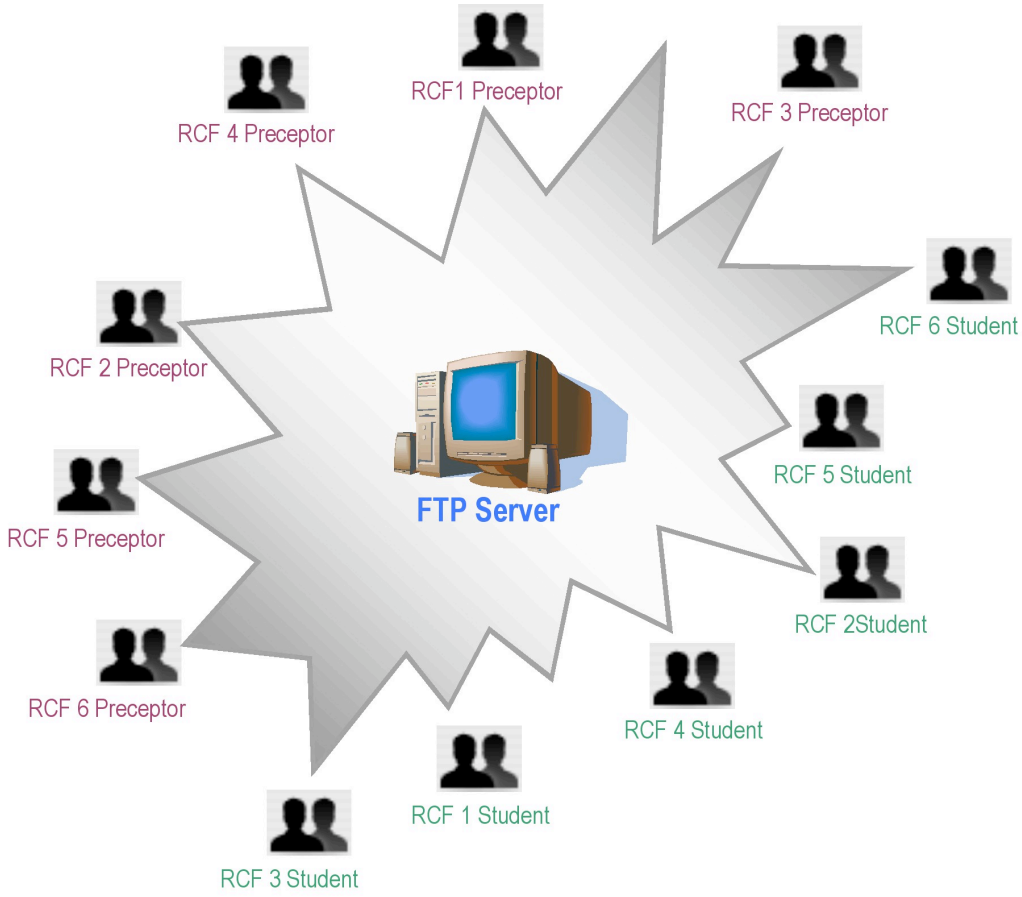
The 'log' was analysed using descriptive statistical procedures. The majority of information collected was categorical data; consequently there were few non-parametric statistics that would have elicited meaningful information. Additionally, due to the low number of respondents involved in the study, it was inappropriate to use statistics to obtain levels of significance.

IT Interface – reciprocity and sharing of data

Because of the wide geographical spread of facilities participating in the project combined with an imperative to give the participating students and preceptor secure access to the weekly case notes, as outlined in the Stage 1 report, a secure Internet 'drop site' was established consisting of twelve 'drop boxes' using an FTP server. The intent was to ensure the participants' anonymity and confidentiality. This site was co-developed by a systems analyst and the project manager and provided a single repository from which all preceptor and students groups could obtain research case notes. A key advantage of this system was that information could be easily and safely distributed to geographically dispersed participants (see Figure 1).

Information on how to access the FTP site was provided to the students involved in Stage 2 of the project during a workshop with the Project Manager prior to the commencement of the practicum. Passwords were provided to the students during this on-campus meeting. The preceptors were provided with passwords during their first research meeting.

Figure 1: Electronic distribution of research case notes



Because of problems accessing the site, early in Stage 1, the FTP site was upgraded to provide the students and preceptors with functionality to login through a HTML web page by entering their username and password. The project web site is at: http://www.healthsci.utas.edu.au/SNM/ftp/index.html (see Figure 2).

Figure 2: Project web site

IT access issues

As outlined in the report of Stage 1 of the project, the intent of the case notes was to provide a first level analysis of the meeting and to promote the participants' critical reflection on the issues raised. This required participants to have read and reflected on the notes from one meeting, prior to each subsequent meeting. The case notes also formed an integral part of the feedback loop. In instances where case notes were not accessed or read prior to the meetings, the process was compromised. This was cause for concern because like Stage 1, despite the best efforts, both students and preceptors experienced numerous difficulties with accessing the case notes via the secure FTP site.

The problems identified in Stage 1 together with the recommendations from the Stage 1 report led a number of the RACFs to purchase and/or updating their computer systems prior to Stage 2.

In Stage 2 the use of a secure FTP site was only partially successful. While the preceptors reported that they were generally unsuccessful in their attempts to access the server, interestingly the students reported a slightly higher access rate. It must be acknowledged however, that unbeknown to the research team, the university IT support had installed a firewall preventing off–campus access to particular aspects of the SNM website, thus preventing access to the website for the first week. It is unclear why this occurred other than perhaps to prevent a breach in security during the time the server had not been in use between stages. Following the removal of the firewall, the students reported a greater ability to access the case notes, whether it be from home, the library or indeed in some cases the same facility in which the preceptors were unable to gain access. To add to these problems it was evident that in one facility a security barrier was in place, which prevented staff from accessing the Internet from the facility computers.

Consistent with the recommendations made in Stage 1, the preceptor groups elected one person from each site to be responsible for the access and distribution of the case notes. However, similar, to Stage 1, IT literacy skills among the preceptors remained a significant problem in many cases.

Nevertheless, for preceptors' weekly access to the FTP site varied. For example, preceptors at one North–west facility could access the FTP site some weeks and not others. In the weeks preceptors were unable to access the case notes, they were emailed to the key link person and to the home email addresses of other preceptors. Incredibly, many of the email addresses supplied were not working reliably.

Staff at the second North–west facility were unable to access the FTP site at all, so the project manager organised to fax the relevant **research case notes** to the key contact person who was a member of the preceptor research group, having phoned them immediately prior to ensure she was with the fax when the notes arrived. This ensured that the confidentiality of the **research case notes** was maintained at all times.

In the southern RACFs, 6 preceptors noted improvements made with respect to the IT infrastructure in their facility. However, preceptors in both southern facilities experienced difficulties in accessing the FTP site so case notes were emailed to each participant by the relevant project research officer. To further compound these difficulties, many participants in the southern facilities also did not have consistently functioning email either at work or from home.

Due to similar access issues, case notes were either emailed direct to participants or hand delivered by the research assistant in the northern facilities.

3. Research design

Participants

University of Tasmania (UTAS) investigators

- Dr Andrew Robinson: Senior Lecturer, SNM, Project leader.
- Mrs Louise Venter: Lecturer & coordinator of the Practice Strand of the BN program, SNM.

Aged care facility partners

- The Director of Nursing from each of the participating aged care facilities.
- 31 registered and enrolled nurses who act as preceptors to nursing students on clinical placements in the aged care facilities.

University of Tasmania student nurses

- 40 second–year nursing students involved in the SNM unit Supportive Care in Hospital and Community Settings — **20 in Stage 1** (Semester One 2003) and **20 in Stage 2** (Semester Two 2004).

Project Steering Committee

A project Steering Committee oversaw the conduct of the project and provided advice to the project team. Membership of the committee comprised:

1. The project leader (Chair)
2. The coordinator of the SNM BN Practice Strand
3. The project manager
4. Directors of Nursing from the participating RACFs.
5. Assistant State Manager (Tas.), Aged and Community Care, Commonwealth Government Department of Health and Ageing.
6. Student nurse representative.
7. Senior Lecturer Rural Education Development, University Department of Rural Health, University of Tasmania.
8. Preceptor representative.
9. Consumer representative.
10. Representative of Aged and Community Services Tasmania.
11. Directors of Nursing involved in the Making Connections in Aged Care project.

Project research team

The project team comprises:

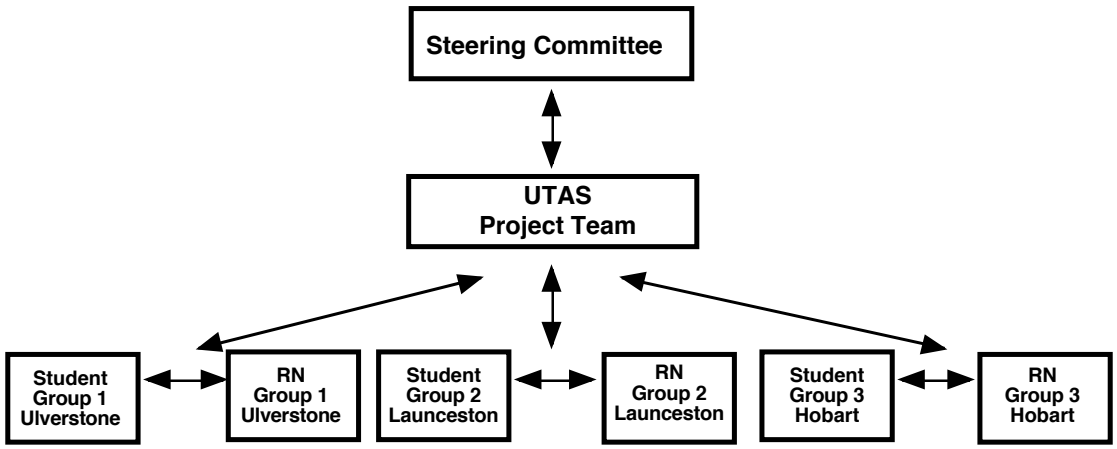
1. Dr. Andrew Robinson:	Chief investigator — senior lecturer, SNM.
2. Mrs Louise Venter:	Investigator, lecturer/coordinator BN Practice Strand
3. Ms Katrina Cubit:	Project manager
4. Ms Linda Jongeling:	Research assistant
5. Mr Brett Menzies:	Research assistant
6. Mr Matthew Fassett:	Research assistant
7. Mrs Carey Mather:	Research assistant
8. Ms Sharon Andrews:	Research assistant
8. Ms Caroline Gray:	Administrative Officer

The project team has met weekly either face to face or via teleconference to discuss the work in progress and to conduct ongoing evaluation. Meetings have also been held with sessional research assistants on a regular basis for data analysis (MF and CM). Ongoing organisational work was conducted by the Administrative Officer (CG).

Project structure

The structure of the project is summarised in Figure 3 below.

Figure 3: Project structure



Stage 2 of the project was conducted in six RACFs located in both rural and regional areas. It involved 20 second–year students enrolled in the Bachelor of Nursing course at the School of Nursing & Midwifery (SNM), University of Tasmania. The practicum constitutes a component of the second year undergraduate Bachelor of Nursing unit *Supportive Care in Hospital and Community Settings*.

Project time lines

Table 2: Project timelines – Stage 2 in bold

Task	Sept 03	Sept-Oct 03	Nov 03 – Feb 04	April–May 04	June-Aug 04	Sept-Dec 04	Feb–March 05
Stage 1: Phase 1 — Preparation							
Stage 1: Phase 2 — Clinical practicum Semester Two 2003							
Stage 1: Phase 3 — Evaluation, data analysis & reporting							
Stage 2 Phase 1 & 2 Clinical practicum Semester One 2004							
Stage 2: Phase 3 Evaluation, data analysis & reporting							
Stage 3: Professional development							
Stage 3: Reporting and evaluation							

Details of Stage 2

Stage 2 had three phases (see Table 2).

Phase 1: Preparation — 2 months

- All preceptors provided with a copy of Building Connections in Aged Care: Stage 1 Report (Robinson et al. 2002).
- Additional preceptors recruited in each institution to make up for those who had left.
- Research team meet preceptors to seek feedback on the Stage 1 report and their response to the recommendations contained therein.
- In consultation with their respective DONs, the preceptor groups developed plans to address the relevant recommendations made in the Stage 1 report.

- Amendments to the project evaluation submitted to the University of Tasmania ethics committee.
- Consent to participate obtained from new preceptors and all participating students.
- SNM meetings held with involved RN preceptors to outline the students' course content and expectations of the practicum.
- The three preceptor groups (North–west, North & South) participated in the first Stage 2 research meeting with the project officer assigned to facilitate the research in their region. At these meetings they elaborated the strategies put in place to facilitate the students' practicum in Stage 2.

Phase 2: Students clinical practicum — 1 month

- 20 students undertook a three-week clinical practicum in participating aged care institutions.
- The project officer in each region facilitates weekly parallel focussed group discussions with the respective RN and EN preceptors and students, consistent with the project methodology.
- Student evaluations completed.

Phase 3: Evaluation, data analysis and reporting — 3 months

- Preceptor groups evaluated their practice as preceptors.
- The research team developed the first report, which addressed the findings of Stage 2.

Stage 2 Output

- Report development that addressed the Stage 2 project findings.

Recruitment

Student recruitment

Students enrolled in the unit *Supportive Care in Hospital & Community Settings* were allocated by the unit coordinators to the six RACFs. Allocations were made following due consideration of their home address i.e. whether they lived in the north-west, north or south of the State. **The student participants also included four recipients of CACNSS scholarships**.

Prior to commencing their practicum the students allocated to the project facilities met with the research staff to:

- explain the project, their involvement and seek their consent to participate;
- receive instruction on how to complete the Supervision and Placement Activities Log;
- receive their usernames and passwords to access the FTP site;
- learn how to access case notes via the FTP site; and
- complete the initial student survey, part A.

At this meeting students were also informed that if they chose not to participate, this would have no impact on their progress in the unit.

All students assigned to project facilities chose to participate, primarily because they saw the project as providing support structures, which would assist them during their clinical

placement. A total of 21 students participated. However, one student withdrew from the practicum mid–way through due to family issues.

The placement of students in Stage 2 was organised as outlined in Table 3.

Table 3: Stage 2 student placement by RACF

Facility	Number of students – Stage 2
RACF 1	3
RACF 2	3
RACF 3	3
RACF 4	4
RACF 5	4
RACF 6	3

Preceptor recruitment

Each facility was responsible for determining which registered and enrolled nurses would participate in the research project. Of the preceptors involved in Stage 1, 21 continued into Stage 2. The primary reason for non-participation in Stage 2 related to preceptors having left the facilities or taking annual leave however, there were no instances where Stage 1 participants deliberately chose not to participate in Stage 2.

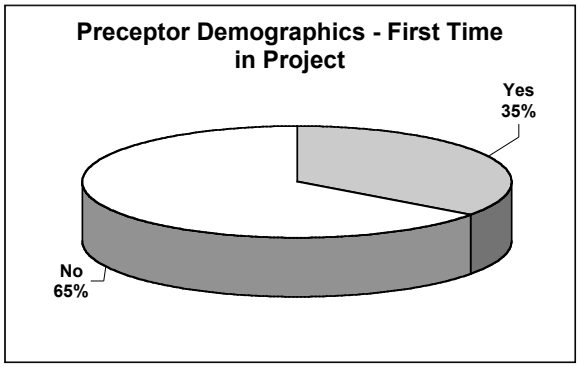
A number of additional enrolled and registered nurses were recruited to participate in Stage 2. In the first instance these nurses were nominated by their respective DONs. Subsequently they met with the project investigators to discuss potential involvement and if agreeable to sign relevant ethics consent forms. In all 10 additional preceptors participated in Stage 2.

As demonstrated in Figure 4, 67% of the preceptors involved in Phase 1 also participated in Stage 2. The breakdown of new preceptors in each facility is outlined in Table 4.

Table 4: Number of new preceptors for Stage 2 in each RACF

Facility	Number of new preceptors
RACF 1	2
RACF 2	1
RACF 3	2
RACF 4	0
RACF 5	3
RACF 6	2

Figure 4: First time preceptors in the project the project



Preparation of students and preceptors

Student preparation

This was the students' first major clinical practicum. Prior to this, in their first year, they had participated in 10 one-day placements in acute and aged care facilities where they had acted as observers. Students in the first year of the Bachelor of Nursing program have a focus on wellness and primary health care. The focus of the unit Supportive Care in Hospital and the Community, in year two of the Bachelor of Nursing, is on the individual and their family during an illness experience in an acute, community or aged care setting. The students are prepared by specific laboratory sessions where they practice a range of nursing interventions. Prior to their first clinical placement, SNM made a concerted effort to formally address the importance of the nurses' role in the provision of what is often described as 'basic' care. This included how to conduct a bed bath, assist a person onto a bed-pan or commode and manual handling. Students were given the opportunity to practise these skills in the nursing labs with their colleagues. The students had been introduced to holistic care using a person-focused approach to the development of nursing care plans and interventions in the theoretical component of *Supportive Care in Hospital and Community Settings*.

With respect to the administration of medications, students involved in Stage 1 were required to successfully complete the *Medication Management for Nurses* package (University Department of Rural Health 2001) prior to the placement. Students in Stage 2 were required to complete Modules One and Four of the package prior to placement. These students will complete the remainder of the package in Semester Two after their placement.

The SNM also teaches a theoretical unit *Perspectives on Ageing* which seeks to problematise the field of aged care and looks theoretically at ageism and ageist attitudes. The students involved in Stage 1 of the project had all completed this unit. The students involved in Stage 2 undertook the unit after their placement, in Second Semester, 2004.

Preceptor preparation

Four weeks prior to the students' placement, a letter detailing the nursing skills they were expected to consolidate was sent to each RACF (Appendix 11). The intent of this letter was also to highlight that they were relative novices to the practice setting. The letter also made explicit that unlike the students involved in Stage 1, they had not already completed a three-week placement in an acute care context.

In each facility the educators were also provided with a comprehensive information package detailing the students' prior learning and prior practical experience including assessment and specific objectives to be obtained on placement. It was anticipated that this would be disseminated to all the facility staff. Further to this, the facilities were invited to nominate a time for all staff, both registered and enrolled nurses, PCAs and general staff, to meet face to face with the unit coordinator. In order to provide additional support to the staff a 'hot-line' phone number was provided. This was available 24 hours, 7 days a week and was utilised freely by both staff and students.

Attendance at weekly meetings

Preceptor attendance

Similar to Stage 1, participation rates in Stage 2 of the project were very good (see Table 5) especially during the times the students were in practice (weeks 2-4).

Table 5: Preceptor attendance by region

Week	Number of Attendees by Region			*Average attendance rate by week*
	North	***North–west***	***South***	
1	7	8	9	*89%*
2	7	8	8	*85%*
3	8	8	7	*85%*
4	4	8	7	*70%*
5	4	6	5	*52%*
Average attendance rate by region	*75%*	*76%*	*80%*	

North–west

There were ten preceptors who initially agreed to be involved in the research meetings on the North–west. For the first four meetings, two different preceptors (from RACF 3) were unable to attend meetings because of pre-existing arrangements and a night duty rotation. Four preceptors were unable to attend the last North–west meeting (three from RACF 3 and one from RACF 4) because of annual leave and medical appointments. On several occasions, preceptors from the North–west attended meetings on their 'days off'.

South

Initially there were ten preceptors involved in the research meetings in the South. However, after two meetings two members of the initial group went on leave. A large number of preceptors gave apologies for the meeting in the Week 5 due to unplanned problems with sickness and associated staff shortages, which meant they were unable to leave their facility to

attend the last research meeting. Like their colleagues in the north west, on most weeks a number of preceptors from the southern group attended meetings on their 'days off'.

North

There were eight preceptors who initially agreed to be involved in the research meetings in the North. All preceptors from one northern facility attended all meetings. Attendance by preceptors from the other facility was sporadic either for unknown reasons or because of staff shortages, which meant they were unable to leave the facility to attend a research meeting.

Student attendance

There were a total of 20 students; 6 in the Northern region, 7 in the North–west, and 7 in the South (Table 6). The average attendance rate across all regions was high, especially in the North–west where 100% of students attended all meetings. One of the North–west students attended even while on sick leave.

Table 6: Student attendance by region

Week	Number of Attendees by Region			*Average attendance rate by week*
	North	***North–west***	***South***	
1	6	7	6	*90%*
2	5	7	7	*90%*
3	6	7	7	*95%*
Average attendance rate by region	*81%*	*100%*	*95%*	

One student was absent from the second meeting in the North, with all students attending meetings in week 1 and week 3 (one student withdrew from the practicum due to family reasons).

All students from the North–west attended all meetings, as was the case in Stage 1.

One student was absent from the first meeting in the South, but all students attended the meetings in week 2 and week 3.

4. Background data

Facility information

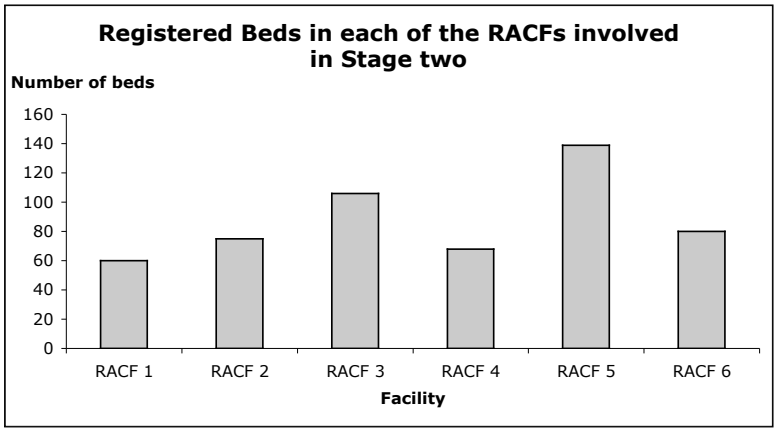
All six of the RACFs involved in Stage 2 were contacted by email, and by phone to collect information regarding their bed numbers and staffing ratios. As can be seen from Table 7 the facilities vary considerably in size. Of note RACF 6 had increased in size by 30 beds since Stage 1.

Table 7: Number of resident beds by RACF (July 2004)

RACF Number	Number of Beds
RACF 1	60
RACF 2	75
RACF 3	106
RACF 4	68
RACF 5	139
RACF 6	80

By combining the number of high and low care beds registered for each facility the relative sizes of the facilities can be compared (Figure 5)

Figure 5: Number of registered beds in each RACF



Staffing profile for each participating facility

The staffing profiles highlight how RACFs have a large proportion of part–time and casual staff (Table 8). It is interesting to note the substantially higher number of PCAs employed by the largest facility, and that this facility also employs the third least number of registered nurses (16), and the highest number of enrolled nurses (20). The smallest facility appears to have the highest registered nurse to resident ratio.

Table 8: Staffing profile by facility (July 2004)

Location	RN		EN		PCA	
	full time	part time/casual	full time	part time	full time	part time/casual
RACF 1	2	14	-	3	-	25
RACF 2	1	17	2	5	4	47
RACF 3	3	14	1	7	-	43
RACF 4	2	13	1	8	-	30
RACF 5	1	15	2	18	-	99
RACF 6	2	10	1	8	-	40

Staffing profiles per morning and afternoon shifts (Table 9) were obtained from DONs or Human Resource staff in each facility. As would be expected, the largest RACF rosters the greatest number of staff per shift. This data shows that RACF 1 did not roster any ENs to work on the morning or afternoon shifts during the time the students were in their facility.

Table 9: Staffing profile per shift by facility (July 2004)

Location	Students	Morning			Afternoon		
		RN	EN	PCA	RN	EN	PCA
RACF 1	3	2	-	7	1	-	4
RACF 2	3	1	2	11	1	2	7
RACF 3	3	2	2	8.5	2	2	5
RACF 4	4	2	2	10	2	2	8.5
RACF 5	4	1	6	19	1	3	13
RACF 6	3	2	3	8	1	1	6

Table 9 also highlights that facilities roster either one or two RNs for the morning and afternoon shifts. Of note, while RACF 4 and RACF 5 both took 4 students, interestingly, half the number of RNs were available per shift in RACF 5 compared to RACF 4.

Student demographics & expectations

Figure 6 below shows the age distribution of the student cohort in Stage 2 as compared to Stage 1. It demonstrates that the Stage 2 students were somewhat older, with around 45% being 30 years or older. In contrast all Stage 1 students were under 35 years of age. Of note the majority of students in both Stage 1 and 2 were in the 18–25 year age group.

Figure 6: Student nurse age

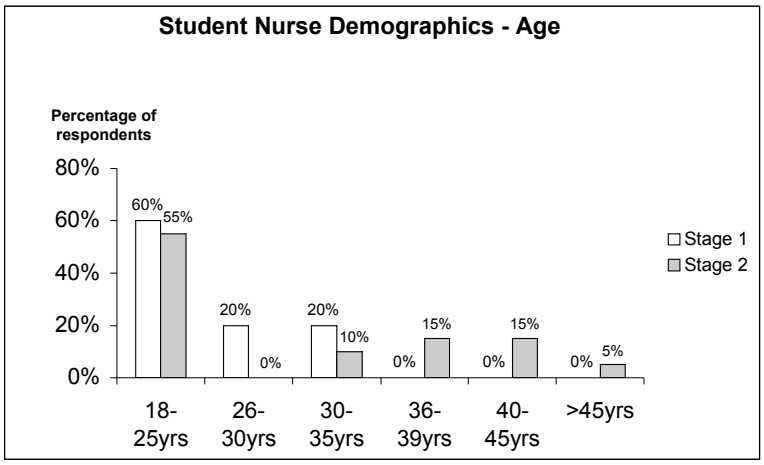


Figure 7 depicts the Stage 2 students' prior experience in an aged care facility compared to Stage 1 students. This shows that 15% fewer Stage 2 students had prior experience working in aged care. Of those 100% worked as PCAs, compared to 91% of the Stage 1 cohort (see Figure 8).

Figure 7: Previous aged care experience

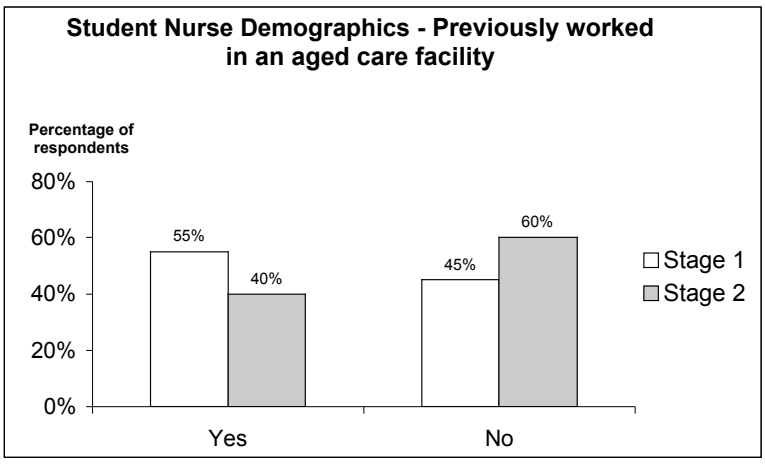


Figure 8: Previous aged care role

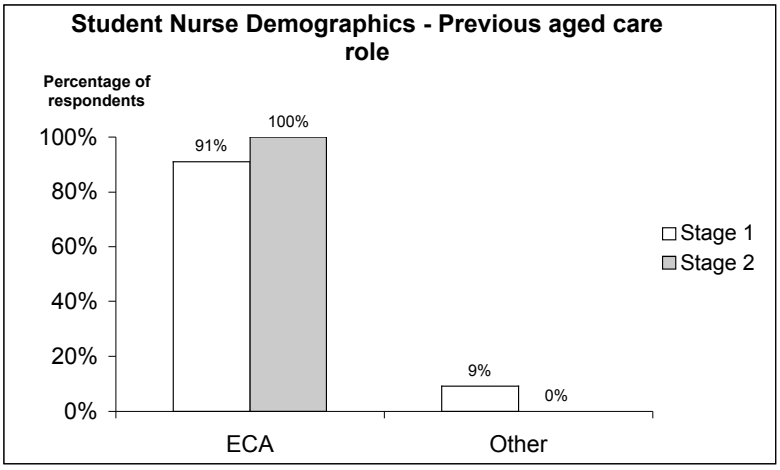
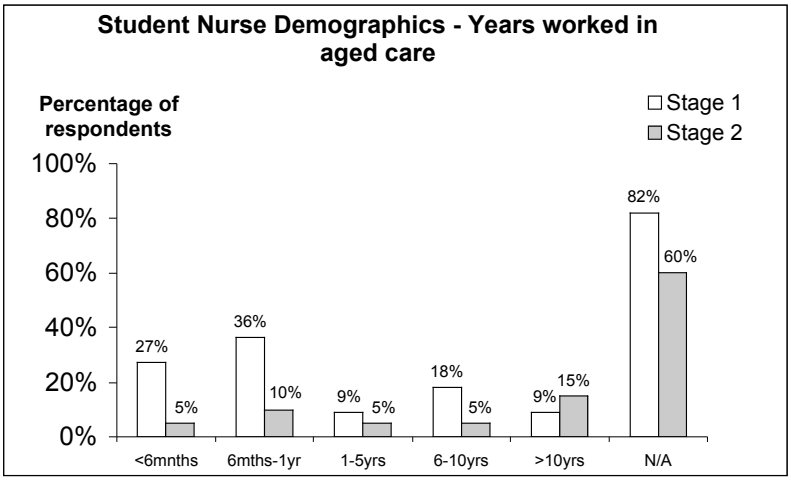


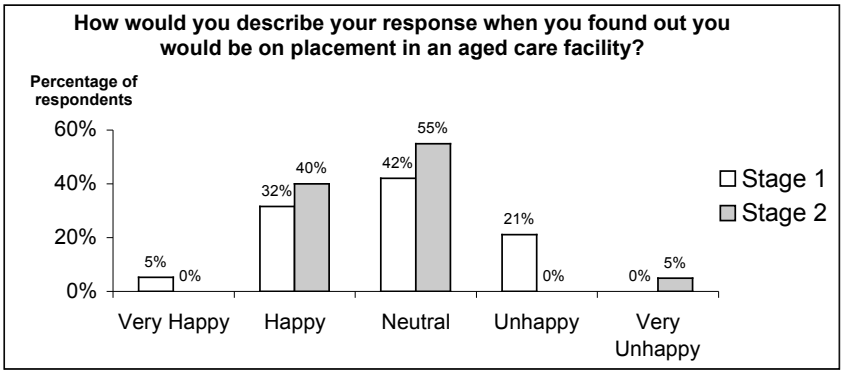
Figure 9 shows that despite being an older group, the students involved in Stage 2 had worked in aged care for a shorter period of time, except for those students who had worked in the sector for >10 years.

Figure 9: Years worked in aged care



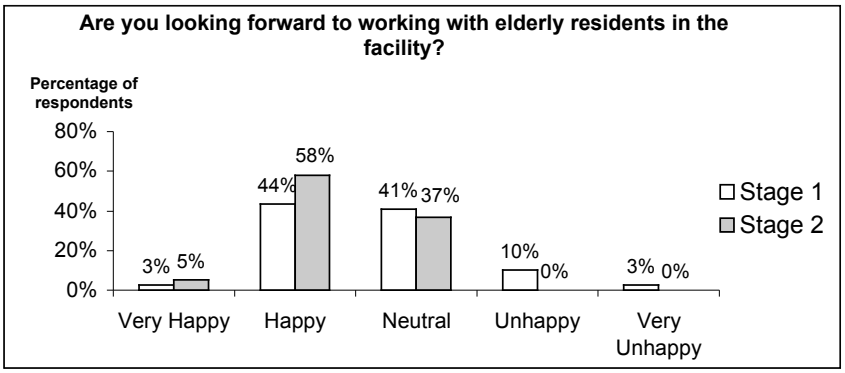
The students' response to being informed that they would be on placement in aged care is outlined in Figure 10. It is apparent that in Stage 1, 21% of students were unhappy at the prospect of undertaking a placement in aged care, while in Stage 2 students were either 'happy' or 'neutral', with 5% being 'unhappy'.

Figure 10: Response to being informed of the placement



Student expectations of working with elderly residents are documented in Figure 11. This shows that in both Stage 1 and Stage 2 most students were happy or had neutral feelings about their expectations of working with the residents.

Figure 11: Attitude towards working with elderly residents



Preceptor demographics

Figure 12 shows a comparison between Stage 1 and Stage 2 preceptors. It demonstrates that around 55% of the preceptors were > 45 years of age.

Figure 12: Preceptor age

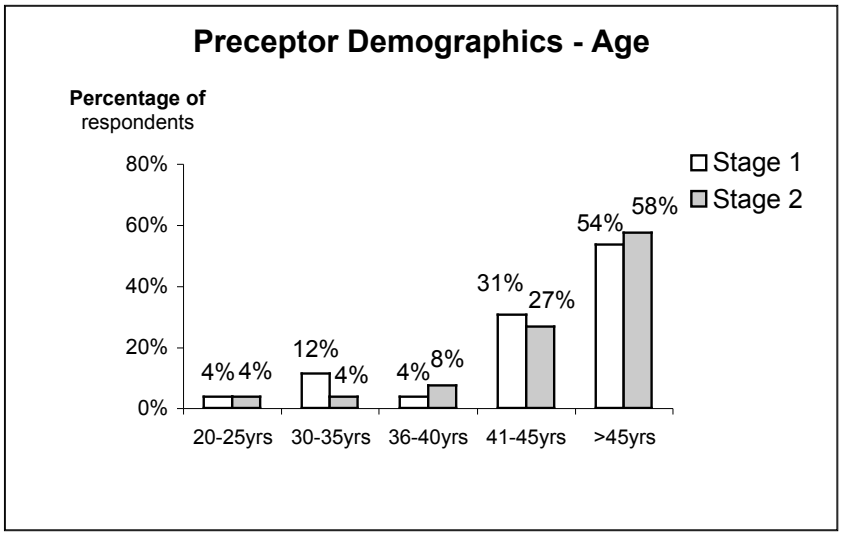


Figure 13 demonstrates that the ratio of RNs to ENs participating in the project in Stages 1 and 2 was roughly the same, with slightly fewer RNs being involved in Stage 2 (65%).

Figure 13: Preceptor roles

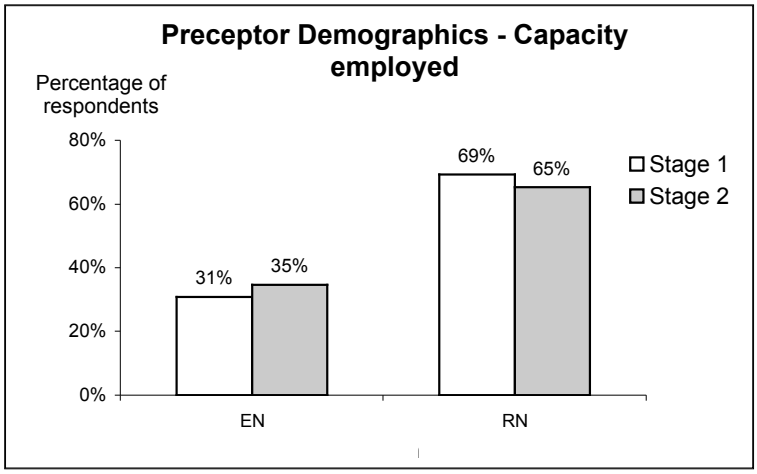


Figure 14 below illustrates that the majority of preceptors had significant experience in the sector, with nearly 85% having = or > 6 years experience in aged care. The figure shows that Stage 2 participants had worked in the sector slightly longer than those involved in Stage 1.

Figure 14 and Figure 15 demonstrate that despite the addition of 10 new preceptors to the research groups the profile of their experience in aged care or the facilities hardly changed.

Figure 14: Number of years preceptors have worked in aged care

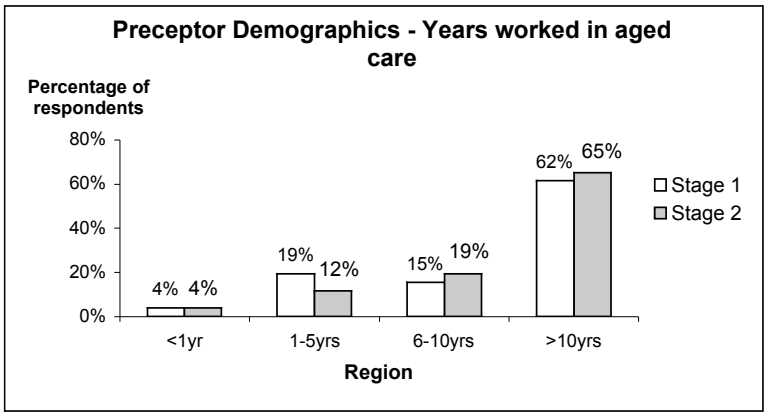


Figure 15: Years worked in current facility

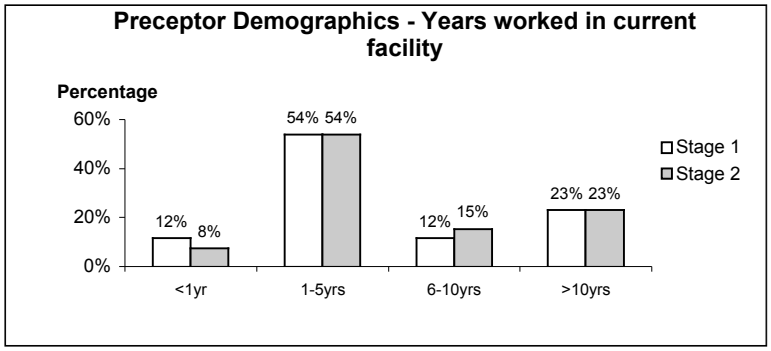


Figure 16 highlights that a slightly greater percentage of the Stage 2 participants had undertaken recognised preceptor training courses prior to the commencement of this project (see Table 10 for a breakdown of these courses).

Figure 16: Preceptor prior training

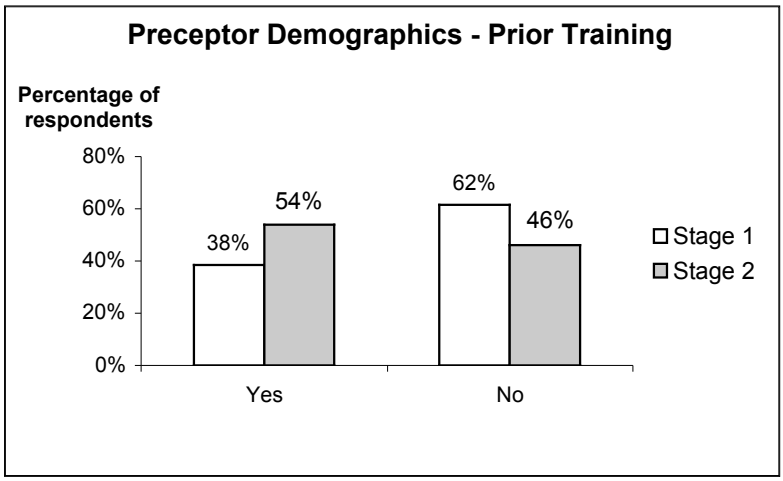


Table 10: Type of preceptor training undertaken

Qualification	**Frequency**
NBT Assessor	6
Preceptor Course	1
Previous Project	1

Similar to Stage 1, in Stage 2 around 40% of the preceptors reported they had a postgraduate qualification (Figure 17).

Figure 17: Postgraduate qualifications

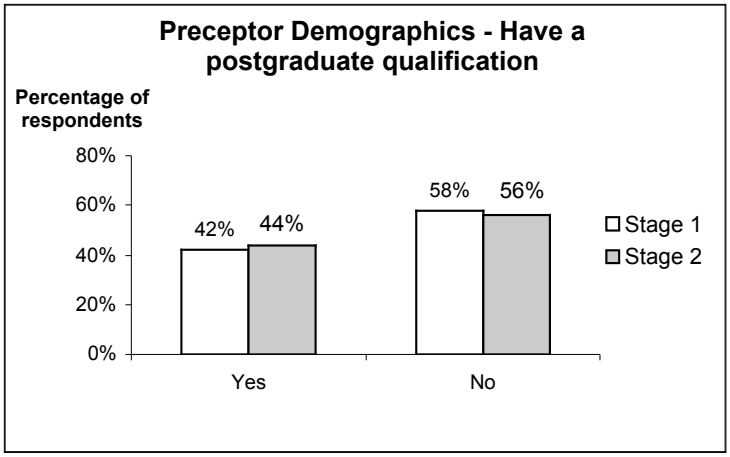


Table 11 highlights that the most common type of postgraduate qualification is Midwifery. It is also apparent this cohort of nurses has limited postgraduate qualifications.

Table 11: Type of postgraduate qualification - Stage 1 and Stage 2 comparison

Qualification	Frequency	
	Stage 1	Stage 2
B App Sc (Nursing)	1	1
Midwifery	3	5
Gerontics	0	1
Theatre course	1	1
Dip Remedial Massage	0	1
Dip Shiatsu Therapy	0	1
CIV Assessment & Workplace Training	1	1
CIV Frontline Management	0	1
Medication Endorsement	1	1
Palliative Care Certificate	1	2
Dip Family & Child Health	0	1
Endoscopy	1	0
Unit 1 of the Aged Care Post Graduate Certificate	1	0

5. Findings

This section provides an overview of Stage 2 and is structured so as to illustrate the changes that occurred as a result of the preceptors' attempts to implement the Stage 1 recommendations.

Preparation for the arrival of the students

Prior to commencing Stage 2 of the project, the project investigators conducted site visits at each of the six facilities. The intent was to discuss ways in which the recommendations made in the Stage 1 Report might be implemented in readiness for the arrival of the second cohort of students in May 2004. These meetings provided the impetus for the preceptors' planning for Stage 2 of the project.

Staff preparation

The findings of Stage 1 highlighted problems with the preceptors' knowledge of students and their expectations of what activities the students could engage in whilst on placement in the facilities. They also illustrated that in a number of facilities other staff, not directly involved in the project, had a limited understanding or knowledge of the students and that this negatively impacted on their experience. In response to these concerns the Stage 1 report made the following recommendation.

- **In consultation with the DON, the members of the 'Building Connections in Aged Care' research group in each RACF will hold meetings with other staff who will work with students on placement in the facility. At these meetings they should discuss the students' previous experience, learning needs and strategies to facilitate teaching and learning.**

Each of the facilities pursued a range of strategies to address this recommendation.

Firstly, because of the difficultly in meeting with staff, in part a result of the combination of busy workloads, high level part-time employment and shiftwork, a number of strategies were utilised by the respective research teams to inform staff of the impending arrival of students. These included notices placed around the facilities or clinical memos distributed to staff informing them that the students were about to commence the clinical placement.

Additionally, all facilities held formal or informal meetings (or both) with other staff. Issues variously addressed at these meetings included the expectations held of staff regarding students, in particular that they be welcoming and friendly. As preceptor 2 reported, *'I said things like "we want to give them a really good experience", be friendly, show them where to put things'*.

In most facilities, preceptors were also provided with an education pack informing them of the students past experiences and expectations of the practicum. Central to this was additional information provided by the SNM.

Information on students supplied by the School of Nursing & Midwifery

In response to the problems, due to the apparent lack of knowledge that many staff had of students and the associated feeling of being unwelcome experienced by some of them, identified in Stage 1, the following recommendations were made in the Stage 1 report.

- **SNM teaching staff should consult with members of the 'Building Connections in Aged Care' research groups to revise the documentation sent to aged care providers regarding students on placement, so that it better meets the information needs of staff.**
- **Members of the SNM should meet with members of the 'Building Connections in Aged Care' research group, and other staff, in each RACF to disseminate information and discuss the student's previous experience and learning needs. The first of these meeting should be held at least 6–8 weeks prior to the students entering practice, to enable the RACF staff to plan the practicum (see below regarding orientation and rostering).**

Prior to the students' arrival in the facilities, the SNM supplied information regarding what they had done in terms of practical work and what was expected of them. Approximately 5 weeks prior to the students' arrival a letter addressing the dates and times of practice and a brief overview of the unit *Supportive Care in Hospital and Community Settings* was sent in an information package to each facility, together with a copy of the Clinical Placement Workbook and the students' names. The SNM also invited all facilities participating in the clinical practicum to attend one of the information days held either in the North, North West or South of the state, where information about the students would be discussed.

Comments made in the first preceptor research meetings indicated that the revised information distributed by the university was well received by the facilities. As preceptor 16 noted:

> *… [it] actually tells them [staff] what … they can do to help the university students … what the university students need from them … So they have a better understanding*.

Similarly, a member of a different research group commented:

> *It gives us guidelines on what they have covered and that we can refer back to. It's more information than we had last time. This is what we asked for because we previously had no idea.*

These and other comments indicate that the information supplied by the SNM was informative. However, it is important to note that on occasions there were delays in the transfer of this information from the DON to facility staff. That is, staff only found out about it at the preparatory meeting held with the project investigators, discussed above.

Student orientation

Planning student orientation program — incorporating Stage 1 recommendations

The findings of Stage 1 highlighted significant problems at most facilities with the processes employed to orientate students. Indeed, this issue was the subject to a key recommendation in the Stage 1 report. This recommendation stated:

- **In consultation with the DON members of the 'Building Connections in Aged Care' research group in each RACF should develop a plan for the orientation of students into the facilities.**

A number of additional recommendations were made to facilitate this process including the use of the checklist used in Stage 1 evaluation (Appendix 5), a member of staff taking responsibility for coordinating orientation, the allocation of preceptors to students and appropriate start times on the first day of the practicum. All the preceptor groups addressed the issues raised in the Stage 1 report, and developed and implemented strategies to address this recommendation. As preceptor 17 noted, *'I went through the recommendations and ticked off things*'.

As such, in each facility:

- The orientation checklist used in the Stage 1 evaluation was adapted for use in each facility.
- A member of staff was given responsibility for coordinating the orientation of students and the dissemination of information regarding their arrival to staff in the facility. This was generally a senior RN within the facility or, if available, an educator.
- Members of the 'Building Connections' research group in each facility were assigned to individual students as their primary preceptor.
- Students commenced work on the first day of the practicum at a time that allowed staff to spend appropriate time with them to facilitate an effective orientation (i.e. students did not start work at 7.00am on the first day).
- Wherever possible rosters were developed to enable students to be allocated to their primary preceptor on the day of their arrival.

In order to better inform students on the organisation of care in the facilities and the care requirements of residents, the Stage 1 Report recommended:

- **That each RACF develop a list where each resident's diagnosis and key treatments are documented.**
- **That each RACF develop a 'duty plan', which outlines the organisation of work in the facilities and key activities for each shift.**

In response to these recommendations the facilities compiled an array of information to provide to students during orientation. This included:

- a sheet of resident photos and names to be provided to the students on their first day;
- a resident diagnosis sheet;
- an alert sheet, *'which tells them who's the diabetic, who's an epileptic, who needs insulin, who's got a colostomy'* (developed in one facility);

- occupational health and safety information;
- infection control information;
- an outline of shift duties for the RNs and carers so that the students would know, at any given time of the day, what was generally supposed to be happening within the facility;
- a duty list to help students understand the role of staff in the facilities and what activities they can expect to participate in when working with different staff members.
- a facility information booklet which included meal times, a map of the facility, the location of lockers, staff toilets, and car parking; and
- fire code and emergency codes.

It must be noted that in larger facilities this was a very time–consuming process, due to the large number of residents in the facility. Indeed, the participants in the largest facility involved in the project had reservations about their capacity to collate information on residents given that much of it would need to be produced during staffs' own time.

Other information addressed in the orientation included explanations regarding residents' histories, medication charts, and care plans. One group of preceptors also reported organising a session on back exercises.

The above preparations indicate the preceptors took the Stage 1 recommendations, regarding orientation, very seriously and generally went to great efforts to organise activities in preparation for students. Additionally, in one facility the nurse educator increased her working week from 0.6 to 1.0 FTE for the duration of the students' practice. She believed that working full time might allow her to *'support my staff, so that if they're really busy and something goes wrong ... I can just be there for the students'*.

Implementing orientation

Generally, orientation to the facilities consumed the first day of the placement. As outlined above, students were provided with information related to the RACF residents, routines and procedures. In general students undertook a tour of the facility, were introduced to staff from different departments, and met with the DON.

Such was the significance attached to orientation, preceptor 2 suggested the students were treated *'like VIPs'*. In another preceptor research group, preceptor 28 highlighted the significance associated with being supportive and welcoming to students on the arrival, when she suggested that it was important for them to experience *'no big stress'*.

At the end of the first week with students the preceptors reported on their experiences of orientation. It was apparent they had enjoyed the orientation experience. For example, in the north preceptor 12 reported *'We had a great time'*, while preceptor 2, from another facility, recounted:

> *… we just had a nice day. The students met everybody and found out what was going to be happening and what our expectations were. They were pretty happy I think by the time they went home and they had loosened up a fair bit … whereas they were very tense [on arrival], but walking out [at the end of the first day] they were quite happy.*

Other preceptors relayed similar accounts, with a member of the southern preceptor group, preceptor 26 reporting:

> *The Director of Nursing took the students around for the best part of the morning. I linked in with them about 11.30 am and had a little informal chat about what we'd be doing and how we'd be doing it and told them to see me at any time if they had any problems at all in any way.*

At this first meeting following the students' arrival the preceptors also reflected on the usefulness of the information, which had been shown to them. Some preceptors expressed concerns that given the volume of information given to the students, they may have experienced some level of information overload.

Student experiences during orientation

As noted earlier, this group of second–year students had previously been involved in 5 single days of practice in an acute care context and 5 single days in an aged care facility as part of the first year program. While this was strictly an observational placement, the experience caused anxiety among some students about what the next practical placement might be like. For example, in the northern group student 10 reported that because of this experience she was '*quite worried',* while another member of that research group, student 9 reported, *'I felt like such a burden last time and I got the impression ...[they thought] we would get in the way'.* Similarly, in the southern research group student 16 reported, *'last time [the aged care facilities] didn't have a clue what to do with us or what we were there for. It was like 'who are you?'*

In contrast to their previous experience, it was clear from the students' comments that their orientation to the six RACFs involved in the project was a very positive experience. Table 12 illustrates that in general students received a comprehensive orientation, as well as key information regarding the operation of the RACFs. Indeed, comparison with Stage 1 results highlights a significant improvement.

Table 12: Information given to students during orientation— Comparison of Stage 1 & 2

Question	Stage 1	Stage 2
Were you given an overview of manual handling and lifting policy?	100%	70%
Did one person coordinate your orientation?	81%	80%
Given an orientation to the unit/area (walk around)?	60%	100%
Shown the tea room?	68%	87%
Shown where the fire exits are?	33%	68%
Shown where the toilets are?	83%	100%
Shown where to put your bag?	75%	95%
Told how the shift would be organised - routines?	52%	85%
Told what books/resources are available and where?	67%	100%
Told what the smoking policy is?	53%	65%
Told what times the shifts finish?	89%	100%
Told what times the shifts start?	56%	100%
Told what to do if I feel sick on a shift & need to go home?	21%	75%
Told what to do if you are feeling anxious or upset?	33%	95%
Told what to do if you are running late or can't work that shift?	27%	95%
Told what to do if you need to go home early?	31%	70%
Told what to do when the phone rings?	25%	60%
Told what to doin the event of fire or emergency?	52%	100%
Told when and where you will have meal breaks?	56%	75%
Told where you can access a telephone to make a call?	62%	80%
Told where you can access computing?	48%	100%
Told who to contact if you hurt yourself?	14%	70%
Were you Introduced to domestic & catering staff?	64%	95%
Were you Introduced to ECAs?	63%	95%
Were you Introduced to ENs?	79%	100%
Were you Introduced to other RNs?	78%	100%
Were you Introduced to the director of nursing?	89%	100%

Of note, the findings of this table indicate that despite the efforts of the preceptors in the six RACFs to adopt a coordinated approach to orientation, 20% of students did not perceive that one person was responsible for coordinating orientation activities, while 15% reported not being informed of the facility routines. Similarly the above findings indicate that there was some level of inconsistency in informing students of the RACF policies (i.e. smoking, answering the telephone, going home early, what to do when you hurt yourself) and some key occupational health and safety information (i.e. fire exits). However, it is also evident that the students were consistently introduced to all RACF staff, a key strategy to facilitate their orientation into the RACFs. Moreover, the importance of this became apparent in comments made by students in their first research meeting. Here the students highlighted the importance of facility staff, other than their preceptors, being aware of their arrival. It clearly made a significant impression. For example one student commented *'there were memos on the staff table and the walls and a few places saying that we were coming and please make us feel welcome'*, while student 7 thought this a significant enough issue to comment, *'everybody was aware that we were coming'*. Similarly, student 12 reported:

> *… they have also got the staff ready as well. Not just the preceptors, I mean they have talked to some of the staff and let them know that we are coming … It's been really well organised.*

The evaluation distributed to students at the end of their first week further illustrates the impact of orientation. Figure 18 demonstrates the effectiveness of the preceptors' attempts to educate staff in their facilities on the importance of welcoming students. The students' assessment of feeling welcome in the RACFs represents a marked improvement on Stage 1.

Figure 18: Degree to which students felt comfortable and welcome on arrival in the facilities - Comparison of Stage 1 & Stage 2

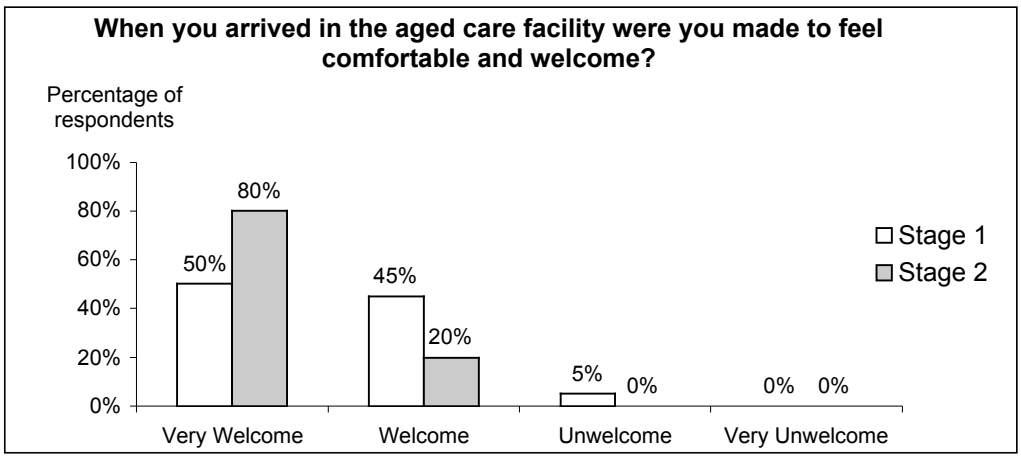
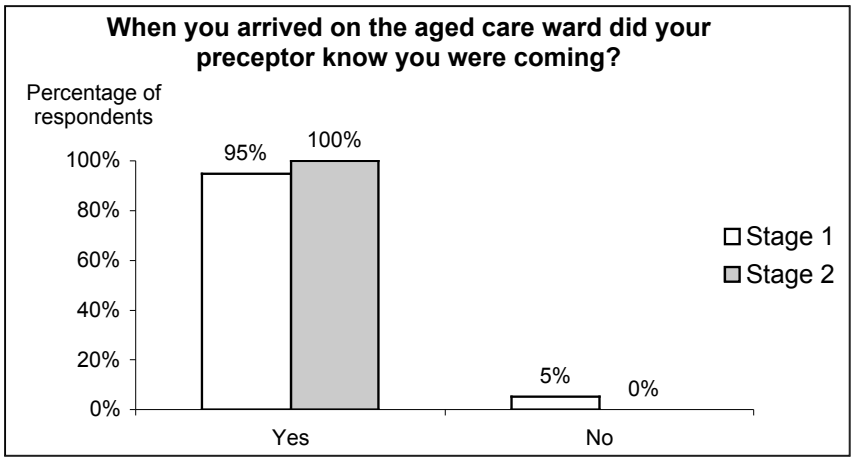


Figure 19 demonstrates that in Stage 2 all preceptors in all six facilities knew the students would arrive on the wards at the allocated time – a slight improvement from Stage 1.

Figure 19: Preceptor knowledge that students were coming to the facility - Stage 1 & Stage 2 comparison



Comments made by students in all three research groups further indicate that their orientation to the facilities was very effective.

For example, in the south, student 15 stated her experience '*compared really well with the aged care placement I went to last year'*. Similarly, in the North–west the students' experiences quickly allayed concerns following their first year practicum, as the following comments indicate:

> *I was very pleasantly surprised with how nice everyone was and how organised everything was. I was really impressed as we walked around the facility they had signs up for us, for what we could do*. (Student 10)

> *It's been good. Orientation was fine they where ready for us. They had done a sheet on what they expected us to do each shift roughly who we would be working with and what we would be doing every hour more or less*. (Student 7)

> *It was really good. We got introduced to all the other RNs and PCAs and we did fire and safety manual handling and all that type of stuff. And we got told what we would basically be doing each day*. (Student 11)

Students based in the northern facilities further highlighted the positive change in orientation. They felt welcomed and given appropriate information as one student commented when she said, *'It [orientation] was good ... everyone was real friendly you just kind of met everyone as you went but they're really friendly*.' Here the students recognised the significance of learning about fire safety as one noted when she commented that they had the fire drill explained which *'if we were caught up in a fire drill we wouldn't stand there looking silly'*. It was also evident that the preceptors conducted the orientation in a manner that was relaxed and friendly and as one student noted when she said they *'introduced us to a few people so that when we came in for our first day on the floor we weren't like, 'oh my god'*. Yet another commented on the importance of being made to feel welcome, stating that her orientation:

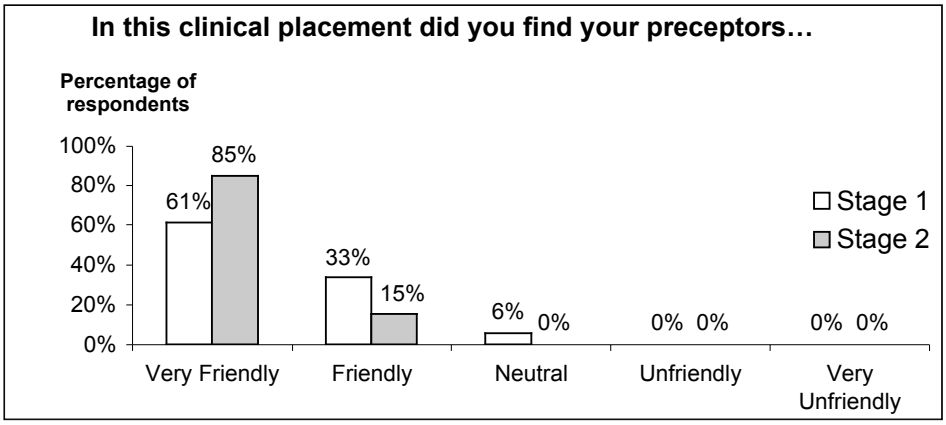
> … *was wonderful because she* [the nurse] *introduced herself and then she said 'everybody come over here and make yourselves a coffee you know or a cuppa and sit down' and then we sort of started talking which was really nice … you were made to feel welcome like you would in your own home*.

Similar experiences were reported from the students on placement in the southern facilities. The reports of student 19 highlighted the effectiveness of the preceptors' preparations, outlined above. She reported:

> *When we first arrived the atmosphere was really friendly, compared to where we went last year, we thought it was excellent. Orientation was really good on the first day. We were given a handout package and given a talk and tour around the place and then given to a RN and she took us a bit further around, and I think we were set free then.*

Figure 20 resonates with the above student comments and demonstrates the degree to which preceptors were perceived by students as friendly.

Figure 20: Degree to which students found the preceptors to be friendly - Comparison Stage 1 & Stage 2



The above findings indicate a significant improvement compared to Stage 1.

Student comments on preceptors included:

- *[I felt] welcome and like they wanted me to learn.*
- *[It made] working in a new institution easier. It made me feel more welcome and more useful.*
- *I was welcomed to be here, and made to feel more comfortable, and able to interact with all staff.*

- *[I felt very comfortable. It is very daunting on your first days and for them to say "I'd love to have you work with me today" gave a good and relaxed first impression.*
- *Wanted, not like a dead weight. Like I had ability and made me feel more like a nurse.*
- *Made me feel like I fitted into to the workplace and that my being here wasn't a bad thing.*
- *I felt welcome and relaxed and this helped me learn and feel at home*
- *The staff were so pleasant and informative and made me feel like I was important*

These findings demonstrate that in Stage 2 the project met the key performance indicator that 70% of students feel well supported during their clinical placements in aged care. They also highlight the importance of feeling welcomed during orientation to the facilities and establishing rapport with preceptors by having the opportunity to work with them over time.

The value of staff preparation

The fact that facility staff were prepared for their arrival and had an organised program was clearly important to the students. In the south, student 16 noted '*we got introduced to our team. They all knew about us and everything'*. Furthermore, student 15 reflected that being made feel *'useful'* and *'welcome'* gave her the sense of '*wanting to make something of [the practicum]*'. Student 16 summed up the importance of an effective orientation by describing the first impression of an organisation as '*the base line for the whole experience'*.

Other students reported similar experiences, noting the importance of being given direction as to what activities they would be involved in and how the shifts would be organised. Similarly, it was evident the orientation package provided to students was seen as an important resource, as student 17 reported when she said:

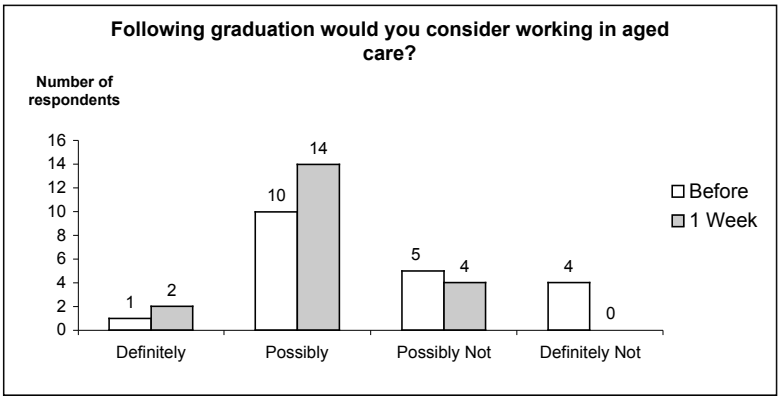
> *In the* [orientation] *package was residents' rights and responsibilities, emergency procedures, staff requirements. There was a staff mission statement just a lot of different handouts, few handout sheets from our wards that we were on, our timetables, and the RN that we would be with that time. It's pretty detailed, it's pretty good.*

In the first week of the placement, student 17 also relayed how evidence of planning by the RACFs set up for a positive learning experience, when she recounted:

> *Yesterday we went to a learning programme on compression stockings and then we went to one … on incontinence, which was good. And we've been told that within the next couple of weeks we get to do a four–hour course on manual handling, so we thought that it was pretty good that we get the chance to do all those things.*

The evaluation distributed in the first week of the practicum further highlighted the impact of orientation. Figure 21 demonstrates the change in attitude to working in aged care from prior to commencing work in the facilities to three days following orientation (i.e. day 4 of the practicum). This change in attitude highlights that an effective and welcoming orientation has a significant impact on students' attitude to working in aged care in the future.

Figure 21: Change in student attitude to working in aged care after four days in practice



These findings illustrate the importance of orientation to setting students up for a positive experience. They also highlight that the preparations of the facilities were highly effective in meeting the students' needs and create a positive and supportive environment. This set up an opportunity to maximize the potential for teaching and learning where students might come to see aged care as a credible and exciting career option. However, as highlighted in previous reports of the research team (Robinson et al. 2002; Robinson et al. 2004), a key to the sustainability of such positive experiences was maintaining continuity between students and their preceptors.

Continuity between students and their preceptors

A key issue identified in the Stage 1 of the project related to concerns with the lack of continuity between students and the preceptors. Like the Making Connections project conducted by the research team (Robinson et al. 2002), Stage 1 of Building Connections identified that a reasonable level of continuity between students and their preceptors was critical to the development of trust, rapport and student problem solving. Indeed, like other literature in these reports continuity was acknowledged as central to the development of an interactive relationship between the two, where students became more proactive in the determination of their learning to achieve competence. Implicit in this was the preceptors' enhanced ability to assess student progress and concurrently facilitate opportunities for teaching and learning. Of note, a critical barrier to continuity identified in Stage 1 of this project was associated with the predominantly part-time nature of the workforce in RACFs (see Table 1 p. 36), which sees only very few nursing staff work full time.

In response to these finding the recommendation of Stage 1 of Building Connections stated an imperative to 'facilitate a greater degree of continuity between students and their preceptors.' Key strategies recommended included:

- **The preceptors' rosters, in the first two-weeks of the students' practicum, should be developed well in advance of the students' arrival in the facility to ensure the greatest level of continuity is possible between preceptor (primary and secondary) and student.**
- **The students' roster should be developed to match as closely as possible with that of their preceptor(s). The SNM should play a key role in ensuring students' know their rosters as long as possible prior to commencing the placement and that they understand the importance of having continuity with their preceptor(s).**

Efforts to facilitate continuity

In response to the Stage 1 recommendations (outlined above), prior to the students' arrival, staff in all participating facilities took considerable time and effort to develop the students' rosters to facilitate continuity between the two. In this a range of approaches were adopted. For example, reflecting on the Stage 1 findings and her experience as a preceptor, in the southern group, preceptor 23 argued that continuity was essential in order to build rapport between preceptors and students, and that this had flow–on effects for teaching and learning. In acknowledgement of the differences between RN practices, she commented:

> *It's good for the student to be able to follow through with one preceptor for a few days at least, before somebody else comes in with a completely different style. It may be confusing if you had a series of four different RNs all approaching someone and doing things differently.*

Moreover, their prior experience heightened the preceptors' appreciation of the importance of developing rapport with students. For example, in the north, preceptor 2 described her plan, which involved:

> *For the first few days they* [students] *will pretty exclusively be working with the RNs. Just to develop that relationship with their preceptors, the people that they are actually going to be spending time with …* [to] *become very close to their primary preceptor …* [and] *to settle in by the end of that first week.*

In another group, the preceptors reported that the students had been rostered to work with 'a team' for the first two weeks of their practicum. It was believed that this arrangement would also facilitate continuity of place. This was important because previous reports (Robinson et al. 2002; 2004) identified continuity of areas, where students undertook their practicum, as an important precursor to their developing:

- confidence associated with increased familiarity with the practice environment;
- independence in their scope of practice; and
- an enhanced sense of satisfaction because *'they got to know the residents'*.

In contrast, the findings in Stage 1 of Building Connections revealed that rotating students between areas had a disorientating effect. Consequently, most groups planned to keep the students in the one area for at least the first two weeks of the practicum and then consistent with the recommendations made in Stage 1, give them the opportunity to work in a new area for the last week to get a more diverse experience of aged care. For example, in the North–west, preceptor 16 argued, *'I just think that hostel is one aspect of aged care but they need to also see the nursing wing which is much more … the residents are more frail.'*

However, despite their best efforts, because of the staffing in aged care, where most staff work on a part–time basis (see Table 8 p. 36), developing rosters to facilitate continuity was very difficult. Because the preceptors were not always at work for a full week it was often very difficult to match students with one nurse and in many instances even difficult to match them up with the same two nurses over most shifts on the practicum. Despite these difficulties, the findings (addressed below) indicate that the groups were generally successful in achieving an adequate level of continuity between students and their preceptors.

Benefits of continuity for preceptors

While the literature extols the benefits of maintaining continuity between students and their preceptors, the students themselves are generally identified as the primary beneficiaries. However, the findings of Stage 2 of Building Connections demonstrate there are also significant benefits for the nurses who have the opportunity to work over time with the same

students. In particular, preceptors involved in Stage 2 identified the sense of achievement associated with seeing the students' competence and confidence develop over time. For example, in the second week of the practicum, preceptor 32 described the importance of working with the same student over successive shifts, saying, *'Because I am there every day with her [the student] I can see how she is progressing each day. I can relate to her and she feels more comfortable being with the same person'*. Similarly, the comments of preceptor 25, from another facility, argued that through working with a student over time:

> *You learn to trust and respect each other and you learn each other's boundaries. It's just an easier way of doing things overall. If you're with somebody new every day it's full on, but you actually can relax into a relationship with the students over a given period of time.*

In this facility, preceptor 30 also reported that seeing her student progress was very satisfying. She commented, '*I love it, I get a real buzz'*. In the same facility preceptor 33 also recounted the benefits of students remaining in the one area. Referring to one of the students, she noted that the '*residents just love her'* and how '*they want to know where she is when she's not there'*. In her estimation, having a student in the area over time had been *'a bit special for the residents'*.

Preceptors also identified the benefits of continuity associated with their capacity to make assessments of changes in student competence, and structure teaching and learning in response. For example, preceptor 30 reported that as the practicum progressed she had been able to gradually increase the responsibilities of her students. This led to a situation where she was able to delegate aspects of resident care, which also had the associated benefit of helping her with her workload. She commented:

> *I can say to X* [the student] '*do a BSL' and she's off and running. So it's great, I'm really enjoying this week. She's demonstrated that she can do it and she's very competent with it, she's done quite a few with me and now she can go off and do her own.*

The students also identified similar benefits. For example, student 9 reported:

> *With a lot of the residents some of the RNs and the PCAs said that it is good having us there, it means that they have got extra people, it means that someone can sit down and spend a bit of time with them* [residents]. *There are a couple of residents that get very anxious and just having someone there for a little bit longer than usual really benefits them, so we are able to do that. I think that it's good for the residents in that respect.*

Such was the importance associated with continuity that preceptors in one facility reported refusing requests to change shifts with a colleague because of the impact this would have on their ability to work with a student over time. Interestingly they also reported that other staff acknowledged the importance of this and accepted the decision gracefully.

Continuity and developing student competence

Similar to the Making Connections project (Robinson et al. 2002) and Building Connections Stage 1 (Robinson et al. 2004), Stage 2 findings revealed that a key benefit associated with high levels of continuity between students and their preceptors is the enhanced capacity to develop student competence. For example, in a northern facility, preceptor 1 argued that continuity facilitated the development of student competence because the nurses could structure their teaching of students in response to ongoing assessments of students developing practice skills. She said:

> *Because I was on last night and again this … I was able to say 'okay, I'm only going to show you once. I'll show you tonight and in the morning you are going to do it'.*

Like the preceptors, the students also commented how continuity assisted the nurses to make appropriate judgements regarding their capacity in practice. For example, in week two of the practicum a northern student commented *'they are getting to know us as well. They know what we can do and what we are capable of doing'*. Similarly, student 19 in the southern research group recounted how working with one preceptor enabled her to *'tell how you are developing in your skills'*, while student 17 in this group suggested:

> *I've had the same person the whole time and she's been really good, because she knows what I've done two days before or three days before and she can say, 'Oh we did that the other day, how about we go and do it again, but this time you can do it …' you know just little things, … so when you rock up the next morning it's just easier when you don't have to introduce yourself to someone new and you don't have to feel uneasy with working with a new person every day.*

This student went on to argue that having continuity with her preceptors had enabled them develop confidence in her *'as a nurse'*, because they had worked with her and knew her *'abilities'*. As such, she reported that as the practicum progressed they would say to her:

> *'Of course student 17 can go and do that', or 'student 17 can assist you with that.' … That's good a confidence boosting thing.*

Continuity also allowed the preceptors to make informed decisions in support of their students in potentially compromising circumstances. For example, one student described a situation in the first week of the practicum when an RN from another part of the facility asked her preceptor if the student could come to her area *'to help out'* because they were *'a staff member short'*. She reported that her preceptor said *'No'*, and was subsequently questioned by the other nurse who queried, *'Can't she do showers?'* She went on to report that her preceptor responded *'Not by herself'*. The student recounted, *'she defended me because I really didn't want to go down* [to do showers]*'*. In contrast the student then stated that by the third week of the practicum *'if someone said, "Quick where is the student nurse we need her to come and help with that" I'd be like, "yeah, ok that's fine"'*. This incident demonstrates the important role of preceptors in protecting students. In the context of staff shortages there can be a powerful imperative to use students as a pair of hands in circumstances where they are unprepared. As this student reflected, *'I felt awful knowing that I might've had to go down and help these people as an extra pair of hands'*. This account demonstrates that students need to be given the opportunity to develop confidence and competence and as has been outlined above, having continuity with their preceptors is critical to this. Continuity also allows the preceptor to make informed decisions regarding what might constitute legitimate expectations of students and protect them in the context of resource shortages. In this way students can have a positive experience of practice reflective of a quality clinical placement in aged care.

Continuity, area rotations and student acceptance

The preceptors' stories also highlight the association between continuity, increasing student competence and the acceptance of students within the facilities. For example, in the third week of the practicum, preceptor 30 argued that because the students had worked for three weeks in one area of the facility, '*they've become part of the team ... because they're recognised by residents and they're recognised around the facility now, so they are, they're part of the team'*. Reports from other preceptors also indicated that the students also valued being seen as part of the team having the capacity to be a material assistance to their

preceptors. In another facility, following the departure of the students, preceptor 23 recounted:

> *When I was talking to them in this final briefing I said something like, 'I hope you haven't felt used or that we've made use of you.' … and they unanimously said 'Oh no it's great because you consider us, that we're capable and that we are part of the team.'*

Likewise, the students identified similar benefits. Student 19 described how being able to work with the same people over a period of time had been beneficial in a number of ways especially amongst the carers who now viewed him as part of the team suggesting, '*if the carers are busy they'll come and find you to come and assist them*'. In this, student 19 felt he had '*increased [his] confidence'*, while student 15 described similar effects when she commented on the benefits of not '*feeling like a dead weight'*. Further indication of the link between continuity of areas and the development of student confidence, students also reported that having the opportunity to provide ongoing care for the same residents in the same area of the facility had a positive impact on their confidence. For example on the North–west, student 11 said:

> *I got to know the residents all pretty well … I got to know them all by name and what is wrong with them and how they have their drugs.*

In this same group, student 9 attributed the growth in her confidence with *'Just being in the same place and getting to know the residents and the PCAs and staff'*. Similarly, in the southern student research group student 17 recounted:

> *One of the ladies I care for has a few dressings that need doing. My preceptor will just say, 'Do you want to go and change that dressing on her foot. You know what goes on, you know what to put on her now'. And then you can take on the responsibility … which has been good.*

Another member of this group, student 19, also commented on the impact on her confidence to relate to residents as a result of staying in the one area over time, when she said:

> *When I first started here I found it pretty difficult to go in and just chat to* [the residents] *but now I've become quite confident with it and I just find different things to talk about with them. There's one guy I've spoken on the ward with, I looked through his notes and found out he was a professional fisherman in his early life. I just talk to him about that, you really don't see him smile that often but when you talk about that he just beams.*

Other students in the southern group reported similar benefits. For example, student 14 argued that continuity of area had enabled her to *'know the residents better'* and as such in the last week she '*was able to do most of the work for people that were high care, be in control of it and do it all by myself and just have a carer helping'*. In contrast, student 10 in the northern group argued, when *'you go to a different place and you have to start all again ... this is hardest thing that I have found'*. Such comments were supported by students in North–west, one of whom, student 11, commented on the impact of rotating between wings of the facility at the end of week 2 made her feel *muddled up again*.

In some facilities it was apparent that despite the plan to rotate students through different areas in the third week of the practicum, as outlined above, they often preferred to remain in the same area for the entire three-week period. For example, in a northern facility, preceptor 17 reported that *'two of the girls asked if they could continue in the first area because they felt comfortable.'* They also reported that the other two students were also happy to stay in the same area during the third week. In acknowledgement of the need to be flexible and responsive to the students' identified learning needs, and the growing rapport between the students and their preceptors which saw students feel comfortable to make such requests (see Section 7), the preceptors reported they were happy to accommodate the student's request.

Interestingly, in other facilities where students either agreed to change areas, on reflection some of the preceptors debated the efficacy of this approach. For example, in one southern facility, preceptor 30 suggested that it may have been better for the students to stay in the one area to give them an opportunity to build *'up on their team work'* and thereby gain *'a better insight into what actually happens on the floor'*.

The final evaluation completed by students further reinforced the value placed on being able to provide continuity of care for residents (see Figure 22) – a capacity directly associated with working in the same area of the RACF over time. When asked the question about the importance of providing continuity of care to residents and their families related to students' intention to work in aged care following graduation, their response indicated that this provided a significant attraction to working in the sector (see Figure 23 below).

Figure 22: Importance students attach to the ability to provide continuity of care to residents

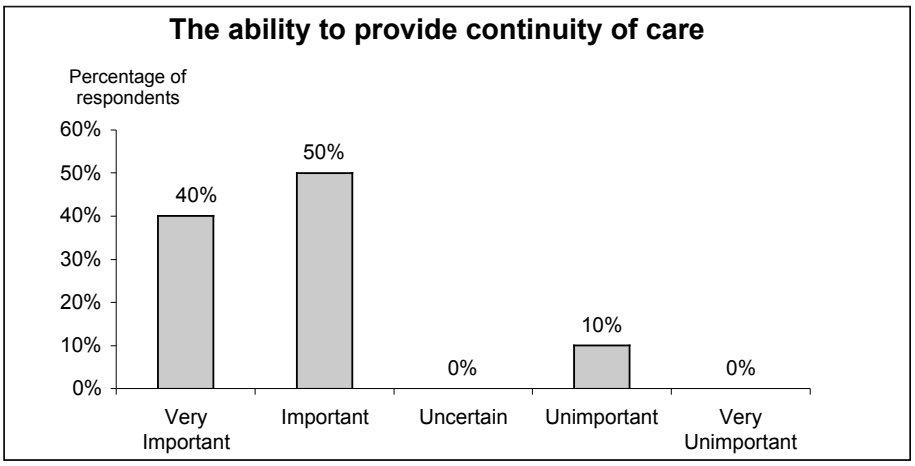
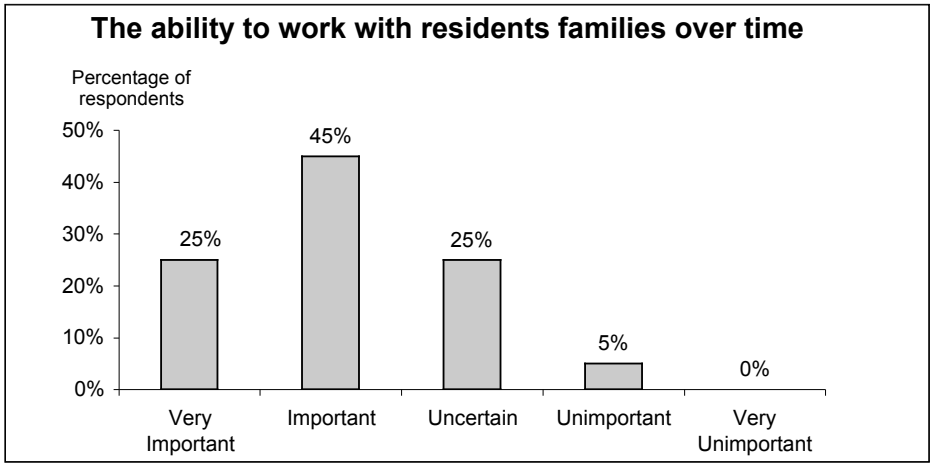


Figure 23: Importance students attach to working with resident's families over time



Benefits of continuity – students

Discussions in the student meetings revealed that having continuity with a preceptor had a positive impact on their clinical placement. This was evident even as early as the first week. For example, after being informed of the proposed rosters during orientation at the first research meeting, student 18 stated with some expectation:

> *I've got the same preceptor the whole time so that should be good. She'll get to know what we know and what we've done and what we haven't done. She will know what you struggled with or what you were comfortable with and be able to take it from there.*

This comment indicates that students appreciated the efforts their preceptors made to give them the best possible chance to have a positive and productive learning experience in the RACFs. Moreover, such benefits were borne out in practice. For example, at the first student research meeting in the south, student 17 stated:

> *I've had the same nurse for the whole time. It has only been for three days, but we've got to know each other so well compared to when I first said 'Hi, how you going?' She knows what I like, what I don't like, what I don't feel comfortable with and that's a big advantage I think, because I feel comfortable with her now.*

Student 17 went on to describe to the group her sense of feeling *'vulnerable'* and how having the same preceptor made her feel '*comfortable about doing things you wouldn't normally feel comfortable doing*'. Another member of that group, student 14, concurred and stated that having the opportunity to spend the majority of her time with her preceptor was '*absolutely awesome'* because she allowed her to '*try different things'* under her supervision.

Mid–way though the practicum, the comments which students made in the research meetings indicate they recognised that continuity with preceptors was critical to their developing confidence. In the north, student 12 suggested *'I think it is a lack of continuity that really unsettles.'* By the third and final week some students expressed sadness that the placement was over because they were now confident and happy to be delegated responsibility by their preceptors. As student 4 stated:

> *I am a bit sad to leave now. This week we were given more responsibility I feel. Like doing it [clinical activities] on your own, other than just checking everything, they know you can do it, so they let you go ahead and do it. That's really nice. I sort of feel like I fit in now, and people are coming to me and asking me questions. It's really nice.*

The final evaluation completed by students (Figure 24, Figure 25 below**)** further reinforced the benefits of students working with their preceptors over time and how this facilitated the development of a productive relationship between the two. The evaluation also illustrates that students involved in Stage 2 of the project had a considerably more positive attitude to preceptors than those in Stage 1. In part this reflects the preceptors' efforts to support the students in practice and give them a positive learning experience. It is arguable that enhancing continuity between student and preceptors, and between students and the areas in which they work, facilitates such improvements.

Figure 24: Degree to which students found the preceptors helpful - Comparison Stage 1 & Stage 2

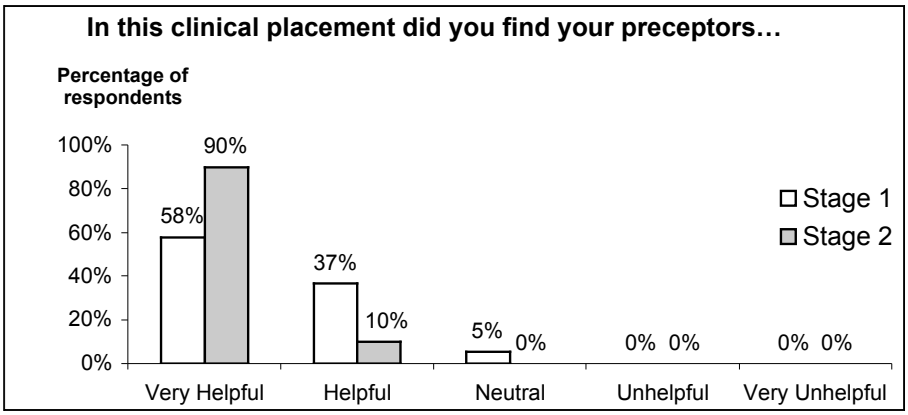
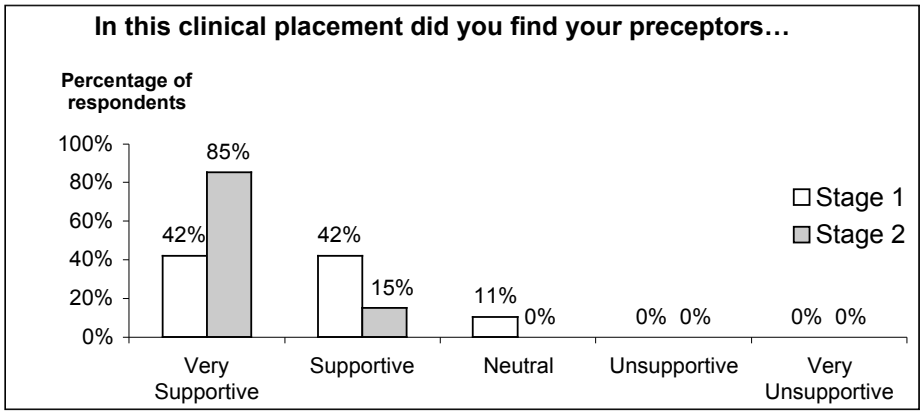


Figure 25: Degree to which students found the preceptors to be supportive - Comparison Stage 1 & Stage 2



Student Activities

Supervision of students

In Stage 1 of Building Connections, the research team collected data on which members of staff students worked with and the activities students engaged in during the practicum. However, the data collection process proved somewhat problematic and the tool used (the Supervisor Log) relatively ineffective. Despite these limitations it was estimated that students spent:

- 40% of their time working with RNs;
- close to 15% of their time working with ENs;
- nearly 20% of the time working with PCAs;
- 5% of the time working with diversional therapists and physiotherapists, and;
- 10% of their time engaged in private study.

To better develop a profile of who supervised the students and what activities they engaged in, as outlined in the chapter 3 and Appendix 10, in Stage 2 of the project a new version of the **Supervision and Placement Activities Log** was developed.

Interestingly, in Stage 2 the students reported that the revised **Supervision and Placement Activities Log** was very user friendly and as a result a 100% completion rate was achieved — that is, all the students involved in Stage 2 of the project completed the **Supervision and Placement Activities Log** for every hour, of every shift they worked (excluding last shift in week 3 and the student who did not complete the practicum because of family reasons).

Analysis of the **Supervision and Placement Activities Log** provided detailed information on the number of hours per week each student worked either directly with or under the supervision of RNs, ENs and PCAs. Additional categories included time alone, absences, sickness or time spent with university staff – primarily involving participation in the weekly research meetings.

Overall, the Stage 2 'log' revealed that students spent on average/day around:

- 36% of their time working with RNs;
- 17% of the time working with ENs;
- 13% of their time working with PCAs;
- 11% of their time working alone; and
- the remainder of their involved other activities

Of the time students spent working alone :

- 46% was related university activities;
- 9% was related to the other activities including watching instructional videos, travelling to research meetings and finding drug information;
- 8% was related to hygiene;
- 5.8% was related to documentation; and
- 4.5% was related to activities of daily living

These results are roughly consistent with the findings of the Stage 1 and suggest that consideration needs to be given to the fact that students spend considerable amount of their clinical placements working with PCAs. However, as outlined in Table 13, the time students spent with different staff in each facility varied considerably. For example, over the three-week practicum on average the students worked:

- 2.85 hours/day with RNs — this ranged from 5.1 hrs/day in RACF 1 to 0.2 hours/day in RACF 5.
- 1.35 hours/shift with ENs — this ranged from 0 hrs/shift in RACF 1 to 3.0 hrs/shift in RACF 5
- 1.0 hours/shift working with PCAs — this ranged from 0.4 hrs/shift in RACF 1 to 2.0 hrs/shift in RACF 5
- The difference with whom students worked in the facilities can in part be explained with reference to Table 3, Table 7, Table 8 and Table 9 which illustrate that:
  - While RACF 1 has 60 beds it employs two RNs on a morning shift and one on an evening shift, whereas RACF 5 employs one RN/shift despite having a total of 139 beds.
  - RACF 5 employs the highest number of PCAs on any one shift — on average 16 PCAs/shift, whereas RACF 1 employs 5.5 PCAs/shift.
  - RACF 1 took 3 students while RACF 4 took 4 students
- Students at RACF 4 reported the highest number of hours working with university staff during the research meetings. This could be attributed to the amount of time they spent travelling between facilities for the meetings.

Other key findings from analyses of the 'log' included: (these figures refer to Appendix 12)

- Across the three–week period, students were sick for 2.3% of the practicum and absent for 1.2% of their allocated time in practice (Table 16).
- Sick leave was highest at RACF 2 (16 hours) and three facilities recorded absenteeism of 8 hours (Table 15).
- A total of 4.6% of the placement time included sick leave and student absence (Table 17).
- Students worked with physiotherapists, community nurses, diversional and occupational therapists, or attended in-service sessions for 4.7% of their time (see category 'other' Table 17).
- Students attended research meetings with university staff for 4.1% of the practicum
- While indirectly supervised by RNs, the students completed documentation (19.4%); university activities including the 'log' and 'episodes of practice' (16.1%); hygiene (11.8%) and medication management (10.8%).

Table 13: Count of average number of supervised hours per student per day

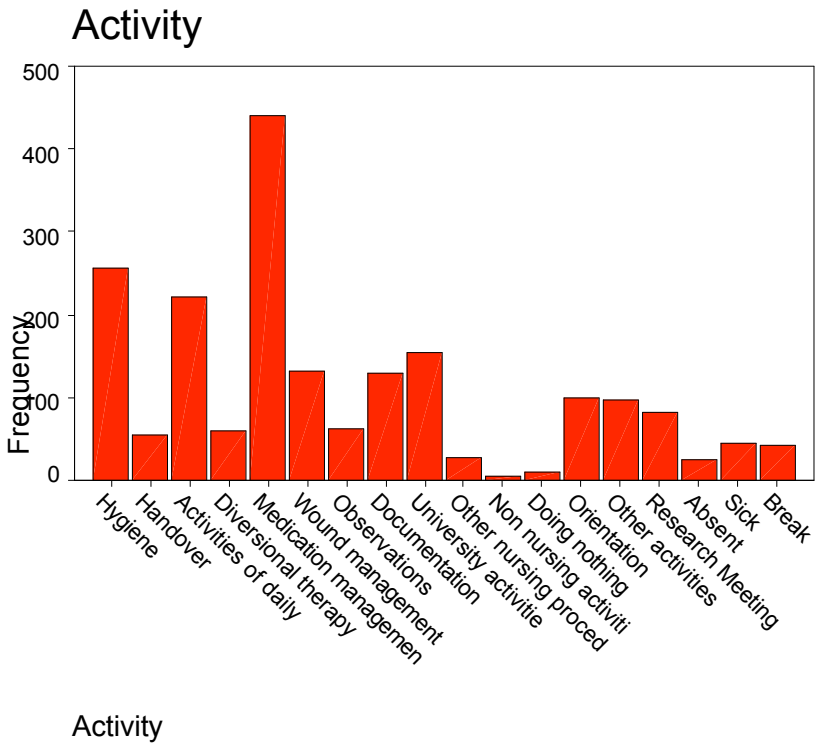
	RCF 3	RCF2	RCF 4	RCF 1	RCF 5	RCF 6	Average
RN	*2.7*	*2.7*	*4.4*	*5.1*	*0.2*	*2.0*	2.85
EN	*1.1*	*0.8*	*0.8*	*0.0*	*3.0*	*2.4*	1.35
PCA	*1.5*	*0.8*	*0.6*	*0.4*	*2.0*	*0.7*	1.0
Other	*0*	*0.2*	*0.6*	*0.04*	*0.5*	*0.5*	0.3
Alone	*1.2*	*0.4*	*0.8*	*1.2*	*0.7*	*1.0*	0.9
Absent	*0.2*	*0.2*	*0.0*	*0.0*	*0.1*	*1.2*	0.3
Sick	*0.5*	*0.4*	*0.09*	*0.2*	*0.0*	*0.2*	0.2
Uni staff	*0.4*	*0.3*	*0.4*	*0.3*	*0.2*	*0.2*	0.3

Table 14: Percentage of average number of supervised hours per student per day

%	RACF 3	RACF 2	RACF 4	RACF 1	RACF 5	RACF 6	Average
RN	*33.8*	*33.8*	*55*	*63.8*	*2.5*	*25*	35.65
EN	*13.8*	*10*	*10*	*0*	*37.5*	*30*	16.88
PCA	*18.8*	*10*	*7.5*	*5*	*25*	*8.8*	12.51
Other	*0*	*2.5*	*7.5*	*0.5*	*6.3*	*6.3*	3.85
Alone	*15*	*5*	*10*	*15*	*8.8*	*12.5*	11.05
Absent	*2.5*	*2.5*	*0*	*0*	*1.3*	*15*	3.55
Sick	*6.3*	*5*	*1.1*	*2.5*	*0*	*2.5*	2.9
Uni staff	*5*	*3.8*	*5*	*3.8*	*2.5*	*2.5*	3.76

Student clinical skill activities

Figure 26: Bar chart showing frequency of each activity



A key concern among students with undertaking clinical placements in aged care is that they will be bored and have a limited opportunity to develop competence in a range of nursing activities.

Analysis of the Supervision and Placement Activities Log revealed that students undertake a wide range of clinical and general care activities while on placement in aged Care. It is interesting to note that the number of student hours spent on each of the different activities and procedures varied across the six facilities (see Appendix 12 Table 15 and Figure 26 above). Key findings include:

- In the facility (RACF 5) where the students spent on average twice as much time working with PCAs (25%) when compared to the average of all six facilities (12.5%):
  - The students spent nearly three times the amount of time involved in assisting residents with activities of daily living (27%), as compared to the average across all six facilities (11%);
  - their involvement in the provision of hygiene care (20%) was significantly higher than the average across the six RACFs (13%);
  - their role in diversional therapy was greater (6%) was double that compared to the average across the six facilities (3%);
  - they spent one third of the time involved in handover (>1%) compared to the average across the six facilities (2.8%); and
  - they spent around half the time involved in medication management activities (13.6%) compared to the average across the six facilities (22.7%).
- While working under the direct supervision of RNs, students mainly undertook medication management activities (49.1% of this time), wound management (13.3% of this time) and orientation on the first day (11.2% of this time) (Table 19 see Appendix 12).

- While working directly with ENs, students spent 32.3% of their time involved in medication management (Table 21 see Appendix 12). However, data collected using the 'log' did not discriminate between observation, planning or dispensing of medication by students. However, if students were dispensing medication under supervision of a medication endorsed EN or EN this is of concern, as they are not permitted to supervise students administering medications.

The range of activities students participated in are represented in the bar chart Figure 26 above.

The achievement of competence in the performance of skills

From the research discussions it is apparent these second–year students on their first substantive clinical placement were very keen to engage in activities that would facilitate their clinical competence. As preceptor 30 suggested:

> *Every time something came up like sutures, or we had some staples, or we had a lancing done of a wound, they were right in there. That was what the students wanted to see.*

As demonstrated by the Supervision and Placement Activities Log (above), the students participated in a range of activities. One group reported that by the second week of the practicum they had undertaken a number of different activities including taking blood, testing urine and sputum, peg feeds, admitting and discharging residents and doctor's rounds. In the second week the North–west students reported that they had *'Looked in ears, watched ear syringing'*, performed *'observations, maintained catheters and dressed a couple of wounds.'* In the north, in addition to drug administration and hygiene care, students recounted preforming insulin and intramuscular injections, the conduct of BSLs, administration of suppositories, catheter maintenance, and urine testing. From their comments it was apparent that in general, the students were enjoying their experience in aged care, and in particular the way the preceptors were teaching them. As student 12 reported

> … *they* [the preceptors] *have been really good, really receptive and want to show us new things. And if some things are happening then they say come on let's go and have a look at this.*

Students also appreciated the opportunity to 'practice' on real people as student 3 argued, when she said *'it's a lot different doing* [something] *to someone who is real, than someone that's not'*.

Strategies to facilitate teaching and learning

As outlined previously, the effective facilitation of teaching and learning within the RACFs was largely dependent on achieving a reasonable level of continuity between students and their preceptors. While this issue has been addressed in some detail above, the students' comments also demonstrate the learning strategies the preceptors employed to teach them.

The demonstration of procedures represented a key learning strategy utilised by the preceptors. For example, student 6 recounted that in her experience when learning to do a new procedure, the preceptors had first *'shown how it is done'* and then given her the opportunity to perform the activity under supervision. She went on to report, *'and then they say do you feel comfortable, go and do it yourself'*. In another facility student 8 reported that her preceptors were *'quite happy for you to observe a dressing, and then to allow you to actually do it'*. Another student recounted an incident, which clearly demonstrates this approach. She said:

> *… today she* [the preceptor] *asked me to go and do a blood pressure. She came with me and she checked it, just to make sure that I had that skill. And then she let me do it on my own the next time … then document it, and then I came back and countersigned it and* [then she] *read through it and make sure I had done it correctly … it's nice that they let you do stuff on your own.*

In another facility, student 16 described being given the opportunity to practice inserting a butterfly needle into pig fat prior to performing the procedure on a resident. She recounted that she did this *'just to make sure I got it in all right … It was good because I had to get it on a really shallow angle so it made it easier'.* In a different facility, student 10 described a similar incident when she told the other group members:

> *I was to give an insulin injection but it was with a NOVO pen. I just said that I had given insulin with a syringe, but not with a pen, so she said right practice on the tea towel on top of the trolley.*

Such accounts highlighted the preceptors were committed to maximising students' learning opportunities. It was a commitment not missed by the students. For example, student 6 reported:

> *I feel they are very prepared to give us time, even though their time is limited they go out of their way to try and give us the extra information or advice, that we seek.*

Similarly, a student in another facility commented:

> *In aged care you don't get paid to be a preceptor, that's the other amazing thing that all these guys are doing, putting all this in for nothing.*

Indeed, from the students' accounts it was apparent the preceptors structured their work in ways to promote teaching and learning. For example, student 15 described how whenever '*something different'* was about to happen in the home, the staff would ask the students if they'd like to '*come along and see this.*' Student 17 commented on her preceptors' '*willingness to provide a good experience'* which she believed caused her to have '*a good attitude as well'*. Similarly, in another facility student 9 recounted:

> *… today I did a urinalysis with my preceptor and I said 'so would you send that specimen off to the pathology'. And she said 'well I was going to ask you that same question.' So she always tries to make you think instead of just giving you the answers straight out.*

Such accounts demonstrate the positive nature of the students' experience in the RACFs. As one suggested *'Now I am glad we went to the aged care first because I … actually got a lot more confident doing most things'.*

Experiences with working with nurses not involved in the project

In contrast to the above accounts, the student descriptions of working with nurses not involved in the research replicate those made in the Stage 1 report (Robinson et al. 2004) and the Making Connections project (Robinson et al. 2002). Despite the best efforts of the preceptors to prepare other staff in the facilities to work with students, it was apparent that in some cases they were very resistant. For example, student 13 described working with a *'RN who didn't appreciate my presence to say the least'*. She found the experience *'very confronting'* and went on to report:

> *I said to her, that I would really like to see some wound dressings. And she said* [in a derogatory way] *'Haven't you done wound dressings?' I said that 'no we haven't'. And she said 'well I don't know what they are doing at the university'. So then I heard all about her theory on university training in nursing, and I did*

> *try and defend myself. I did say to her that we had covered wounds, but that we had done the clean wound field concept, that we had theoretical knowledge, but not the practical knowledge, and that I would like to see what they do with wounds, and what they used. And she just fobbed me off. She said, 'Oh it's all the same and you get to know these things and I don't know what they are not teaching you in the university'. I was peeved to say the least.*

Similarly, in two other RACFs the members of a student research group discussed the difference in working with preceptors who were not directly involved in the project. Student 16 described asking a preceptor who was not involved in the project for help. She recounted that the nurse replied, '*What do you need help for? You did that by yourself yesterday'*. Similarly, student 20 related a story whereby she had worked with a preceptor who was not familiar with what she had been doing. She recounted:

> *… I'd never worked with the nurse and she said to me, 'What are you going to do today?' and I said 'I'll just do what I usually do'. She said 'What's that?' and I told her and she goes 'So what am I supposed to do while you do all that?' because it was pretty much what she would do. I'm like, 'Ok, I don't know. I usually work with preceptor X and that's what I'd do if I was with her' and she was like 'what am I supposed to do?'*

This interaction gave student 20 the impression that the nurse '*didn't know what her job was'* and subsequently described feeling '*a bit blown away'*. Similarly, student 16 described an incident she spent with a nurse who was not involved in the project, when she recounted '*a really bad day'*. In another facility, student 17 described an experience she had with a nurse, reporting that:

> *I had an RN who didn't know about the project. My confidence was flushed down the toilet. She was just not welcoming or anything and she goes 'Well you can just go and do something.' That was the most unproductive day I've had here, I did nothing because she just took charge and just did everything by herself.*

Such comments further highlight the impact of the nurses' involvement in the research in facilitating a positive experience for students. They also illustrate that despite the best efforts of the research groups to inform staff regarding the students' arrival in the facilities and their learning needs, the development of a learning organization will take time and the ongoing commitment of resources.

Accounts of activities

Wound management

Analysis of the 'Supervision and Placement Activities Log' revealed that on average students spent nearly 7% of their time during the placement involved in wound management. Indeed, from their comments in the research meetings, it soon became apparent that the provision of wound care represented a key area where the students had the opportunity to develop their clinical skills. However, it was not always as they expected and some students struggled to come to terms with the look and smell of some wounds. In the second week of the practicum student 7 recounted, '*I had to change a pressure ulcer* [dressing] *yesterday. I had seen them before but this one was gross I nearly threw up.'* On another occasion a student commented how she was taken *'back a little bit, because it was one of the nastier wounds I have seen in the scalp*'. At the same time, the students were clearly appreciative of having the opportunity to provide wound care. As one stated, *'I have learnt so much about that'* while another, student 17, reported that prior to the placement that she *'had no idea what to put on what wound and why you did it, but now I can almost identify with the type of wound we put this*

on'. As highlighted previously, getting to know residents and their needs over time was central to students developing the skill to undertake wound care.

Medication management

Similar to the students involved in Stage 1 of the project, it was apparent that in Stage 2 the second cohort of students also spent a significant amount of time involved in the administration of medications. Indeed, the 'Supervision and Placement Activities Log', referred to above, indicates that on average students spent nearly 23% of their time engaged in medication management. Interestingly, compared to the students involved in Stage 1 the issue and importance of medication administration was less prominent in the research group discussions.

However, despite this all student groups discussed how they had spent a large amount of their time assisting in the administration of medications to the residents. As one student reported following the first meeting, *'We've just been doing drugs. Heaps and heaps of drugs'*. Their accounts also highlight that administering medications was an effective learning process. For example, student 10 recounted

> *… one RN that I worked with the other day, she said 'Ok it is lunch time, here are the lunch time medications, just pretend that I am not here'. She was there of course. So I had to work out which resident was which and I looked at her* [to ask a question] *and she said 'I am not here' … So I had to go find an ECA to confirm that this lady was the lady I was needing. And she just did lots of things like that to make me learn, and asking questions I mean you feel like you have been put on the spot for that spilt second, and then you think 'Now I know this'.*

However, there was some confusion regarding the nurses' responsibilities regarding drug administration with students. The NBT requires that nursing students be under direct supervision when preparing and administering medications (Nursing Board of Tasmania 2003). This caused some concern for the students as some preceptors did not appear to understand what this involved. For example, student 13 queried:

> *I thought that we were supposed to have an RN beside us all the time to take the pills inside the room, but that hasn't happened.*

Furthermore, the students discovered that due to swallowing difficulties, administering oral medications could be problematic for some residents. In discussing this, the issue of crushing pills was raised. In one facility, student 10 reported *'there is a list [of which tablets can be crushed] in front of the medication book'*. However, student 9 argued *'They don't really use that here, cause they believe that it is better to crush medication'*.

In the first week of the practicum some students raised these concerns regarding their being supervision either indirectly by RNs, or directly by ENs, during the process of medication administration — (See Appendix 12 for data pertaining to supervision of the medication management activity in each of the RACFs). In two research groups students' concerns regarding supervision during medication management were fed back to the preceptors via the feedback loop. On receipt of this feedback one preceptor questioned what direct supervision entailed. She felt that it was appropriate to watch students administer medications *'at the door'*, because as she said:

> *I am not going to go in and aggravate the dementias. I am keeping on eye on them through the door, so they feel like we are not watching. Sometimes they can behave well if they are being watched, but that changes if they are not being watched.*

A definition of 'direct supervision' during the administration of medications was likened to *'the student being able to feel the preceptor's breath down their neck'*. During these meetings

the research team cited the NBT requirement that students be supervised directly by RNs during activities that involve medication management (Nursing Board of Tasmania 2003). The preceptors acknowledged this and gave an undertaking to meet the NBT requirements, noting the importance of accompanying students during the administration of medications. However, because of this limitation, students subsequently reported that while they could observe ENs undertaking medication management, they had no opportunity to directly practice this skill. This caused a significant degree of consternation among the students and led some preceptors to question whether the issues of ENs' supervision of students during medication management in aged care needed to be addressed. For example, preceptor 17 argued:

> *… the ENs generally do the suppositories and unless I or one of the RNs make a special trip with them* [the students], *I can't really see what the issue is because they are endorsed by the NBT.*

Subsequently, in one student research group the effectiveness of the feedback loop in addressing this issue was discussed, with the students in one facility reporting that while the issue of supervision during administration of medication did initially improve, their concerns had not been totally resolved. As student 7 suggested, *'it did change immediately after, but one or two of the RNs probably weren't informed'*. When this feedback was provided to the preceptor group they agreed to discuss this matter with their staff including advising all the ENs in the facility that it was not appropriate to supervise students during the administration of medications.

Another preceptor group discussed how they had implemented the feedback they had received from the students regarding the inability of ENs to supervise the administration of medications. In the southern research group, preceptor 23 commented that such a situation was not a problem in her facility because the RNs *'continued to take some time out'* to do medication rounds with students. As preceptor 26 reported:

> *We are starting to get onto it. They're getting quite a lot of observation experience and I'm just trying to do it with them for their particular patient. The ones they are looking after, doing their medication. It's not every day unfortunately.*

It was apparent that in this case the feedback loop was effective because as student 16 commented, *'we have been basically doing the medication round with the RN every day since*'. Similarly student 15 stated that the preceptors had '*countersigned the medication charts every time'*, while in another facility student 17 commented:

> *The RNs made a bit more of an effort this week to try, even if it's only been 5 minutes a day, that was a lot for us. She's made more of an effort and you can tell. She'll come and hunt you down and say let's do some medications.*

However, these discussions indicate that the issues surrounding the supervision of nursing students during the administration of medications in aged care need to be addressed. It is an issue that quite obviously has significant implications for both the nurses and the facilities involved.

Giving injections

As outlined above, analysis of the 'Supervision and Placement Activities Log' revealed that on average students spent around 23% of their time during the placement involved in medication management. While participation in medication rounds represented the bulk of this time, the administration of injections to residents also formed another important component. The students' comments revealed that administering an injection for the first time was a significant moment in their nursing career. For example, in the north, student 6 suggested that *'... It wasn't just giving the injection; it was actually giving the medication and*

drawing it up.' Her subsequent comment give an insight into students' reaction to what is generally considered a routine nursing activity. She recounted:

> *It was a very exciting time for me because I was nervous as could be and my hands were sweaty so I knew I was going ahead to do the big deal. That was really exciting to be able to go ahead and to pull the plunger back, just to see that I hadn't touched any of the vessels and then to go ahead and do it and follow through.*

Student 5 made similar comments when discussing her first efforts at giving subcutaneous insulin when she said, *'it is kind of a funny feeling to realise that you are actually pushing that needle into someone and they can say Ow!'*

In the southern group, student 15 recounted the story of *'mucking up'* her first intramuscular injection, which she described as *'a bit spooky'* and made her feel *'like a real dork'*. This student went on to recount that the experience could have been worse had it not been for her preceptor who commented, '*that could have happened to anyone, don't worry about it*', rather than saying, '*you jerk'*. Indeed, the students' comments suggest that receiving praise and feedback on their performance was important. For example, student 6 reported that following the administration of an injection to a resident:

> *I walked out of the room, after thanking the client for letting me do it, my smile was from one side of the hall to the other I thought, 'wow I have done it'. I was just so scared stiff. It was a good experience and the fact that she said 'you did that well, the patient didn't flinch', which to me I felt 'Oh, yes, I felt really good'.*

Hand washing & hygiene measures

While performing tasks and procedures, the students were acutely aware of the need for strict hygiene measures and infection control procedures. One reported that in one facility the staff *'really insist on really good hand washing techniques'*. However, in some facilities students reported that the implementation of such measures was not as strict as they anticipated it to be. During a discussion on budgets and cost cutting in aged care the students raised the issue of gloves and hand washing. As student 10 reported *'I have noticed that a lot of people do not wash their hands. They will attend to somebody and they will play with their face or whatever and then go into someone else'*. Other concerns raised by students related to staff, particularly the PCAs, not washing their hands between residents, and the limited number of hand basins and soap dispensers where students could wash their own hands. While this issue did not receive the prominence afforded to by the students involved in Stage 1, such findings suggest that the issue of hygiene and infection control needs to be addressed at least within some facilities. However, it is important to also acknowledge that hygiene care and hand washing are also issues of concern in most health care agencies.

Working with PCAs

Stage 1 of the Building Connections report revealed numerous concerns with respect to students working with personal carers (PCAs). This was a significant issue because analysis of the Stage 1 Supervisor Log, completed by students, indicated that they spent up to 20% of their time in the facilities working with PCAs and that this work was primarily oriented towards the provision of resident care. Their comments indicate that in general the PCAs were unprepared to teach them and had limited knowledge of their learning needs, or effective strategies to facilitate teaching and learning. As well, the Stage 1 findings revealed that in the context of their undergraduate training, the nursing students sometimes struggled to accept the legitimacy of this arrangement.

These findings led to the recommendation that PCAs receive additional preparation prior to working with students in RACFs and for students to be given the opportunity to discuss the legitimacy of working with them during clinical practicums. The Stage 1 Report also recommended that the SNM address this issue with students and that the RN/EN preceptors involved in Stage 2 of the project take a key role in facilitating the integration of PCAs into the teaching team. Specific recommendations included the following:

1. **PCAs who work with students on placement in RACFs need to receive up-skilling regarding:**
    - **the students' learning needs; and**
    - **the appropriate focus and strategies to facilitate teaching and learning with undergraduate nursing students.**
2. **Preceptors need to actively support the integration of PCAs into the nursing team in RACFs and thereby support them in their work with students. Funding possibilities should be examined to support the up-skilling of PCAs to facilitate such developments.**
3. **The School of Nursing should address the issue of working with PCAs with all students on placement in RACFs.**

School of Nursing and Midwifery Action

In response to the recommendations made in the Stage 1 report, prior to the commencement of Stage 2, students undertaking the unit Supportive Care in Hospital and the Community (which includes Building Connections investigator Mrs Louise Venter) were provided with specific information related to the staffing structure of aged care facilities and the role of PCAs. It was pointed out to students that the nursing care plans in aged care facilities are of a particularly high standard and meticulous attention is paid to detail and clear communication, considering the care plan is formulated for both for RNs and PCAs to work from. In general the care plans are developed as a team activity, usually with input from PCAs.

It was suggested to the students that it might be helpful to regard the care plan as a written instruction from the RN to the student. As such, because the care plan provides detailed written instruction it represents a valid form of communication between the RN and student and in some circumstances can replace verbal instructions from the RN to the student. In this way the care plan in aged care supports the indirect supervision of students by the RN.

Targeting & preparing PCAs to work with students

At the first research meeting in each region the preceptors recounted how they intended to address the above recommendations. It was evident from the various responses that they had taken the issue very seriously and thought carefully about how best to support students working with PCAs.

The members of most preceptor groups argued that it was important for students to be exposed to PCAs and to have the opportunity to work with them. As preceptor 27 argued, *'Students need to acknowledge the PCAs' role and respect them as a worker and as an important member of the team'*. Similarly preceptor 31 argued that PCAs were the ones *'doing the bulk of the work'* and thus needed to be included in the process.

However, in one facility the rosters were developed to ensure that the students were not allocated to PCAs. In this facility, preceptor 17 reported *'this time on the rostering, they are not actually working with any of the PCAs as such … they're all ENs.'*

Alternatively, other facilities targeted specific PCAs to work with students and spent some time preparing them to work as preceptors. For example, preceptor 16 provided an

information package to PCAs she targeted to work with students. She recounted that she discussed working with students with what she termed were the 'senior PCAs', explaining that she said to the PCAs:

> *… you'll be having students working with you at times during the day and this is what they will need to know and … so when you do a shower umm explain why you are doing it, why you don't use soap, because their skins dry and, try and talk about those sorts of things, why you are actually doing hygiene.*

As a routine part of preparing PCAs to work with students, Preceptor 2 reported that she held debriefing sessions with the PCAs to *'talk about their experiences and how they found it'*. Additionally she described giving the PCAs positive feedback and addressing the issue of preceptorship with PCAs at their annual appraisal to ascertain whether or not they *'want to be a preceptor'*, stating that she was *'fairly choosy about where you put the students and who you put the students with'*. Preceptor 2 went on to say:

> *Those are educated and think about what they are doing, and why they are doing it, step outside of the box to make knowledge–based decisions. We do have a lot of PCAs that do that. So those PCAs will definitely* [work with the students]*, if we can, that's the people that we put a student with.*

Similarly, at the other northern facility, preceptor 12 reported that she had targeted PCAs to work with students who were upgrading to Certificate 4 TAFE qualifications. As she said, *'I have got some very good PCAs'*.

In the south, preceptor 28 reported that she targeted PCAs who appeared interested and appreciated the importance of '*describing the subtleties'* such as '*skin integrity and muscle tone*'. She went onto to say that she might say to a PCA:

> *… you're showering this person and how this can be quite a learning experience for the student in terms of skin integrity and muscle tone.*

She went onto argue *'The PCAs do pick up on the subtleties of change of condition extremely well, they are very observant.'* In this way it was hoped that the students might be given some insight into the decision making processes needed when caring for the elderly and how this was related back to their care plans. Preceptor 28 went onto argue that she was confident to assign students to the targeted PCAs because *'you know that that person will be treated respectfully and be shown what they need to know and they will be allowed to participate, and encouraged'*.

Students' experiences of working with PCAs

As outlined above, in Stage 1 of the Building Connections project it was apparent that many students experienced significant problems when working with PCAs in the facilities. However, in Stage 2 of the project, in general, the students' accounts indicate that the preceptors' preparation and targeting of PCAs was very effective. For example, one student recounted that when she worked with PCAs on one shift:

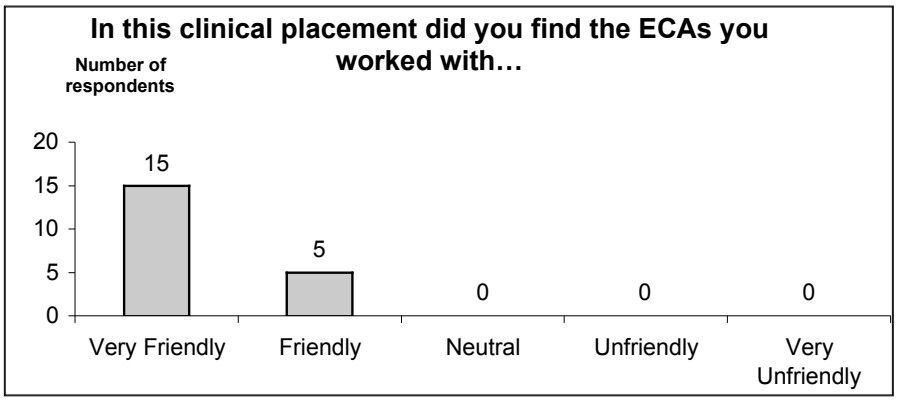
> *We just did showers and I helped do feeds and changing beds and all that kind of thing. The PCAs were all pretty good, they were all really nice. They introduced themselves and said you can come with us and they made me feel like I was useful … they were really good, they said can you do this, and kept giving me little jobs and talking to me and that was good.*

Alternatively, at another facility students spent little time working with PCAs, primarily in the provision of hygiene care to residents. As a consequence, they worked only 5% of the time with PCAs. At this facility two of the three students had previous experience as PCAs and this influenced the planning of their practicum. As a consequence in the first instance, the educator in this facility thought it was important for the students to be clear *'that they are*

here because they are student Registered Nurses'. She went on to argue that it was important for these students to *'look at their role as an RN in aged care'* and as such she rostered them *'to spend most of their time primarily ... with RNs'*. As a consequence, students spent over 64% of their time or over 5 hours per shift working with RNs in this facility (See Table 13 above). Another facility adopted a similar approach and here students only worked 7.5% of the time or less than an hour per day working with PCAs. In contrast, as outlined above, at another facility the students worked 25% of the time with PCAs or on average 2 hours per day.

The final evaluation completed by students (Figure 27), reaffirmed the view that in general they had a positive experience of working with PCAs

Figure 27: Degree to which students found the ECAs to be friendly



However, despite the efforts on the part of preceptors to prepare PCAs, accounts from the students suggest that there are difficulties associated with unregulated workers acting as preceptors to nursing students in aged care. For example, one student described instances where the lifting procedure used with residents compromised occupational health and safety, while another, student 9, recounted her concerns with PCAs labelling residents. She expressed her concern saying the *'PCAs will just label this person as a constant bell ringer and therefore he could get ignored or neglected.'* She went on to report that the RNs *'were wanting to put things into place before that happened.'* Another member of this group, student 10, recognised the limitations of PCA training and how this impacted on newly admitted residents, when she said:

> *… the PCAs aren't looking at the full picture by thinking, this person is new, it's a whole new place, they have never been sick, you know, they're frightened, they're scared and they don't know what is going to happen next.*

Other students recounted experiences where they felt that the PCAs had not provided enough information to prepare them for involvement in a particular clinical activity. For example, student 11 recounted:

> *Yesterday I was showering* [a resident] *with a PCA, a lady with dementia, and she was like ninety eight, and she was like hitting and biting, but the PCA didn't even tell me that she was aggressive before we went in.*

The student went on to report that she subsequently discovered afterwards *'the care plan said "be careful cause she's aggressive towards staff"'*. Similarly, student 9 recounted giving a resident a shower after the PCA had told her *'yep you can do it yourself'*. However, she reported that subsequently an RN said *'you where lucky that she didn't have one of her black out fits on you'*. Critically reflecting on the situation another member of this research group, student 10, argued that because the PCAs get to know the residents so well because *'they are with them more'* that *'why they can be a little bit blasé about things like that'*. Furthermore, another group member, student 8, queried the level of access PCAs have to nursing care plans when she recounted:

> *I asked one PCA where the care plans were and she said 'I've been here three years and I'm not really sure'. I think that most care plans cover what you really need to know.*

The value of working with students for PCAs

According to the preceptors, their work in preparing PCAs to work with students had a positive impact. Preceptor 13 argued that *'I think that our PCAs are more approachable, ... if they see someone* [a student] *standing there, they grab them a lot quicker'.* In another facility, preceptor 28 reported that *'I think the study had a very positive effect on the carers… I didn't get any negative feedback'*. She went on to say that she intended to follow up with the carers and use their involvement in the research and with students as an impetus to facilitate their ongoing professional development.

Moreover, following the departure of the students, the members of the southern preceptor research group reflected on the way that preparing PCAs to work with students valued added to the facilities. For example, preceptor 26 argued that '*the more you get everyone involved, the more they feel valued in their teaching role as well'*. Similarly, preceptor 30 suggested that recognising that the carers had played an important role in facilitating the students' practicum was like '*a pat on the back for the carers'*. Other members of this group also indicated that engaging PCAs in this kind of activity worked to strengthen the care team. As preceptor 28 indicated, *'I think it's a really positive thing to happen, I think it does help the team build together.'* Furthermore, supportive of the comments made by preceptor 26 above, preceptor 28 went onto reflect that it would be appropriate to *'go back to the carers and say we got really good positive feedback from the students and let them know that as well'*. The comments of other preceptors also illustrate that having students in the facilities has the potential to promote professional development among carers. In yet another facility, one preceptor recounted that some PCAs reported that:

> *… they do not know how to answer their* [the students'] *questions because they tend to use the scientific term … Once you* [preceptor] *explain to them* [PCAs] *make it simple, they can say, 'Oh, yes, I know what I should have said now.*

Overall, there was agreement among the preceptors that having students in the facilities provided an impetus to engage with the PCAs in a different way, which in turn promoted cohesion within the care team and the professional development of its members.

Student perceptions of aged care

In the report of Stage 1 of Building Connections an entire section was devoted to addressing issues around the professional context of aged care. It was argued that the context in which students engage in practice in aged care has a significant impact on the nature of their experiences

Stage 2 of the Building Connections project provides further insights into student nurses' perceptions of aged care. As in Stage 1, their accounts are of interest because they provide insights into students' perceptions of aged care, how they make sense of different issues arising out of the practicum and how their perception of these issues can change over time.

Dealing with the 'aged' & 'old bodies'

Dealing with old bodies was one of these issues and this has previously been highlighted as confronting for students (Robinson et al. 2002:39, 54). While this issue was not raised in Stage 1 of the project, in Stage 2 only 40% of the students had previously worked as PCAs

(n=20) compared with 60% in stage 1 (see Figure 7). While students with prior experience in the sector were clearly familiar with 'old bodies', for the remaining 60% of those involved in Stage 2 this was their first experience in caring for older people. Interestingly, both the students and preceptors raised this as an issue.

For example, in the first research meeting, prior to the students' arrival in the facilities, preceptor 4 recalled her first experience with caring for elderly people, commenting that '*having to deal with … old bodies*' was such '*a daunting thing for me because I didn't know what to expect ... it was just really scary'*.

The students also shared stories of what it was like to deal with the ageing body, and like their colleagues involved in the Making Connections project (Robinson et al. 2002) how they were *'amazed'* by the fragility of the residents' skin. As a student in another group commented:

> *… you don't realise until you actually … see a wound or see scars and just rub moisturiser in it you just realize how thin and frail and how gentle you really have to be …*

When referring to a male resident to whom she had been providing care another student in the southern group, student 16, reported that *'I was just surprised by the texture of his skin and how fragile the elderly are. You don't want to hurt them. It's really strange'*.

Such comments indicate that dealing with old bodies is an issue for students with no prior experience in aged care.

Interactions with residents

In Stage 1 the long duration of care activities and the unique nature of aged care was highlighted by students. Indeed it was constructed as a unique opportunity to develop long term relationships with residents and their family (Robinson et al. 2004:35). In Stage 1 these students, who had undertaken a prior three–week placement in an acute hospital, compared this to their understandings of acute care nursing, commenting how it is '*not just the aged people that we are dealing with, but also the family'*.

Similarly in Building Connections Stage 2 students acknowledged the importance of families and the ongoing relationships aged care staff develop with residents. As student 9 commented, in contrast to acute care setting where *'they're here one shift and they are gone the next'* in aged care *'every time that you come back to a shift you have got the same residents'*.

Previously, this report addressed student accounts which illustrated the ways that working in the same area over the course of the practicum assisted them to develop the confidence to meaningfully engage with residents. With respect to the strategies identified by students to facilitate this process, a number commented on the importance of '*sitting down and talking to a resident'*. They argued this was important because it gave them the opportunity to learn about the resident's background, which greatly added to the quality of the placement. However, they also encountered what might be considered a 'generation gap', which meant some of the younger students felt they had little to talk about with the residents. For example, student 17 captured this dilemma mid–way through the practicum when she recounted:

> *I think for me, I find it really hard, I wouldn't want to go into aged care straight out of uni. I think I would want to be older because I find it really hard to relate to the older people. Just little things, the terminology they use. I had a lady talk about how she had a drink of fizzy raspberry cordial and she called it Raspberry Vinegar. Like that's really strange, but that's just what they used to call it.*

This age difference was highlighted as a problem for the same student with the nursing staff who are '*older and it's like these people are their parents' or grandparents' age and they*

know the terminology but I don't feel like I've had enough life experience to hold a decent conversation with these people'. Another of the younger students, student 20, who worked in a different facility related how being young made her feel like *'a little girl'* in the eyes of the residents. She said:

> *This resident thinks I'm a little girl because … he says, 'how old are you?' Today I went in there and he goes 'I really need to go to the toilet, can you get someone more senior than you to come in and put me on the toilet'. I just took it and I said, 'Fine I will go and get someone' and I went and got them and she went in and she came back out and she said that he didn't want to put the young girl through that. He's a funny old man.*

At the same time, the students did acknowledge that in general the residents loved the interacting with them. As student 18 suggested, the residents *'love whatever you're talking about'*. However, it was also important for students to acknowledge that many residents experience problems with their memory. As student 18 noted:

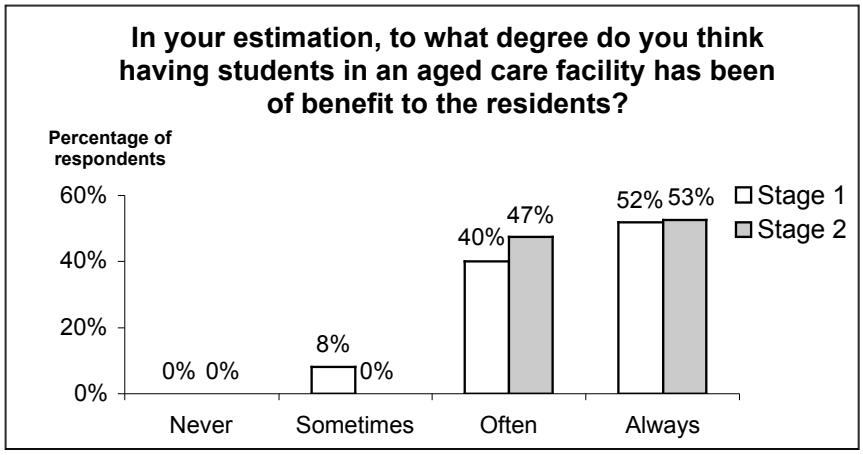
> *The ones that don't remember much, you can talk to them about the same things and the ones that do remember you can talk to them about what you were talking to them the other day.*

The preceptors also acknowledged benefits for the residents associated with interacting with students. For example, preceptor 13 argued that the student interaction with residents was *'good therapy'*. Moreover, the preceptors reported residents taking an active role in facilitating the students' clinical experience. Preceptor 13 went on to say:

> *We actually have a resident who is having their stitches out, so he suggested that the students can share the stitches between them, because he has them on his face and his back.*

The final evaluation completed by preceptors following the departure of students (Figure 28) further illustrates the degree to which the preceptors considered that the presence of students was of benefit to residents.

Figure 28: Preceptors estimation of the benefits for residents associated with having students in the facility - Stage 1 and Stage 2 comparison



The figure demonstrates that in comparison with Stage 1 of the project the preceptors were slightly more positive in their response. This indicates that if anything the preceptors had firmed up their resolve of the positive benefits associated with having students on placement in the facilities.

A touch of ageism

As stated previously, the students involved in Stage 2 of the project had not completed the second–year unit Perspectives on Ageing. As such they had not been exposed to a critique of ageist attitudes or had the opportunity to explore in a systematic and scholarly fashion what they thought of older people.

Interestingly the language used by students in Stage 2 to describe residents was often couched in ageist terms. Students used the language such as *'a funny old man'* and variously described them as *'nice'*, *'grumpy'*, *'cranky'*, *'cute'*, *'posh'*, *'down to earth'* and *'healthy'* acknowledging however that *'you'll get that with all ages'*. Some students also described resident relationships in similar terms. For example, student 17 related, *'We've got couples from different wings that are boyfriends and girlfriends. It's so cute'*.

The use of such language is associated with negative stereotypes linked to the elderly and old age. These stereotypes include helplessness, dependency, illness, feebleness, passivity, irritability, rigidity, forgetfulness and general decrements in cognitive processing (Braithwaite et al. 1986:315; Edgar 1991; Koch and Webb 1996; Chater 2002; Herdman 2002). Additionally, Stevens and Herbert (1997) highlight key stereotypes which characterise the elderly as 'asexual' which is perhaps why the student found it novel and *'cute'* when suggesting that the residents may still be involved in relationships. The use of such derogatory language devalues the residents, highlighting the veiled ageist attitudes of the students concerned.

Aged care is a bit sad

While the students used what they considered to be endearing terms such as *'funny old man'* and *'cute'*, at one meeting mid–way through the practicum the students in one research group considered the plight of residents in aged care. A number of the group members reported feeling that aged care nursing was '*a bit sad'*, or as student 14 suggested, *'really depressing'*. This was especially the case because as student 20 suggested, the nurses *'have to do everything for the residents'*. As student 18 suggested:

> *It's just the way the residents are and they're just so sad some of them, and they're blind and you try to do everything you can for them and they can't hear and you just wonder what their quality of life is like.*

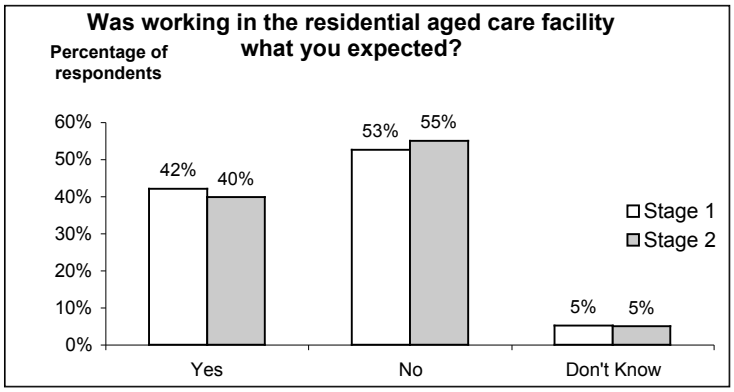
Student 18 went on to offer the view that aged care was sad because '*you know the residents are not going to get any better than what they are. The nursing home is the last stop'* while student 17 further reinforced the difficulties experienced by students when she said they '*say they want to go home and you can't break the news that they are home*'. Indeed the situation of residents shocked students especially in the context of their nursing education where the main focus of study is framed by a medical paradigm, which places a greater value on 'cure' and the defeat associated with death.

Alternatively, students with prior experience of aged care, especially in circumstances where they have a family member resident in the sector, took a different view. For example, one student with prior personal experience with a family member in residential care did not find aged care as *'sad'*. The account shared by student 15 offered some insight from the consumer's perspective. She recounted:

> *I don't find it as depressing as these guys because from my own experience with my dad, some of them are quite ready to go. They don't find it as sad as we do in fact. Some of them are quite at peace with the idea and if it happens tomorrow it happens and that's that.*

The final evaluation indicates that a significant proportion (40%) of Stage 2 students, were surprised by their response to working with elderly residents. The proportion is almost identical to Stage 1 where 37% of students reported surprise. This suggests that the students' perceptions of aged care are challenged by working in the sector.

Figure 29: Students' expectations of working in aged care

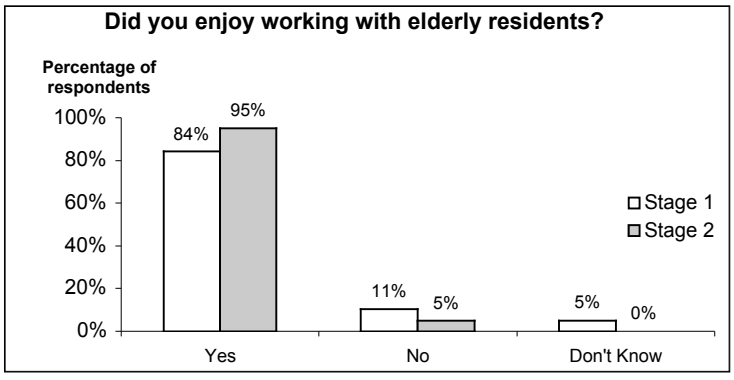


The student response of feeling sad at the plight of residents most probably represents an important dimension of their experience of surprise. Of course, given the experience of students in this project, it is reasonable to suggest that a significant proportion of students were pleasantly surprised, a position supported by the positive shift in student attitude also recorded in the evaluation (see Figure 29).

The consistency of results between Stage 1 and Stage 2 indicate that a significant proportion of students are indeed surprised by aged care. Similarly, the Making Connections project (Robinson et al. 2002) revealed that 40% of the total of 26 involved students reported that working in aged care was not what they expected.

Despite their concerns with the sad situation facing some residents in aged care the final evaluation of students demonstrated that they enjoyed working with the residents.

Figure 30: The degree to which students enjoyed working with elderly residents



Salary issues

The Australian Nursing Federation (2004) reports that the national shortage of nurses combined with the wages gap between nurses working in the public hospitals and those working in the aged care (which currently stands at 21.6% or $170.50 per week national average) exacerbates the recruitment and retention difficulties in the sector.

This issue was the subject of some discussion in the students' research groups and their comments indicate that the lack of salary parity is indeed a significant impediment to their

working in the sector following graduation. In the final week of the practicum students in the North–west group argued that working in aged care was not seen as an attractive option because the lack of wage parity. Similarly the northern group expressed similar sentiments. As student 2 commented:

> *The pay rate is what 17% less than what a normal nurse gets. That is the only thing, which would shy me away from it … I like the work, but it is just that nurses who are doing just as many hours are getting, compared to what the aged care nurses get, 17% less. It is a lot of money. It just doesn't compare.*

This group of students also compared working in aged care to working on building sites, with the latter offering more money and less stress.

The reality of graduating with a HECS debt and the need to pay it off as quickly as possible was also an issue raised in relation to the lower wages offered in aged care. In the north west student 12 argued that if the nurses *'... receive[d] the same rate of pay as the hospitals and for that matter for the other States, then yes they would come in to it.'*

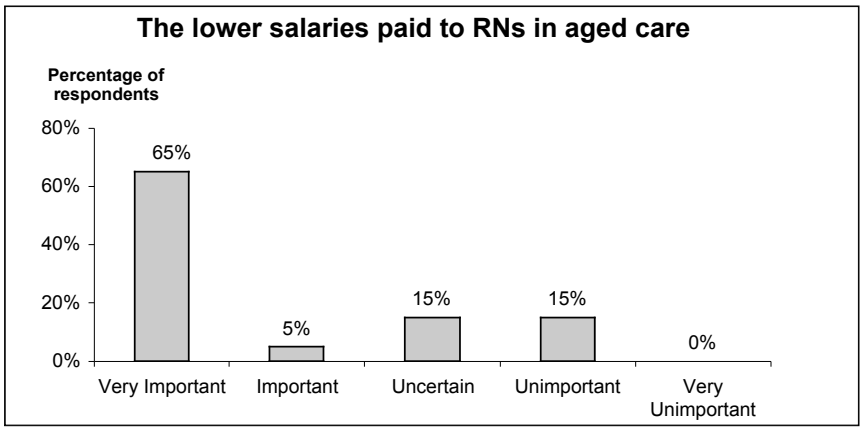
The students also argued that wage parity was important because they conceptualised the role of the RN in aged care as being broader and more accountable. Student 4 argued:

> *I think also that nurses in aged care have more of a responsibility as … than in a hospital setting. Cause you have the doctor always there, backup, whereas here, it's them.*

She went on to argue that *'if you are not getting the same rate they should get more benefits or something'*. Indeed, the students held the view that the contribution of RNs in aged care was undermined by the lack of wage parity, and this is further enforced by comments reported by student 13, such as *'nurses are wasted in aged care'*. Others commented on what they believed to be the general perception of aged care nursing as second rate, while student 11 also reported that she got the impression that other nurses saw aged care as a 'soft option' — *'once they have had their kids then they just want that easier sort of nursing'*. According to the students such conceptions of aged care were reinforced by discrepancies in the salary rates.

Interestingly the final evaluation completed by students addressed this issue. Students were asked to assess the significance of lower salaries on their decision to work in aged care (See Figure 31). This highlights the significance that students attach to the lower salaries paid to nurses in aged care and that this will have a significant influence on their decision making regarding where they work post graduation.

Figure 31: The degree to which aged care salaries would affect students' decision to work in aged care



Students' perceptions of the RN role in aged care

In 'Making Connections' the students commented on how the RNs in aged care provided very little 'hands-on care' for the residents (Robinson et al. 2002:36). Similarly, in Stage 1 of 'Building Connections' the students perceived the role of the RN to include all the *'high stuff'* otherwise known as 'technical care' (Robinson et al. 2004:36). In both these instances the students saw the RNs role to be more administrative and managerial compared with the direct care provided by the PCAs.

Again, in Stage 2, the students discovered that the role of the RN in aged care involved *'not... a lot of hands on with the residents'*. However, some saw this as a positive and appealing aspect of the role. Student 7, who had worked as a PCA in aged care explained:

> *That's one of the reasons that I decided to become an RN, 'cause PCA works too hard. You're just knackered at the end of the day.*

However, the students were also aware that the RNs were extremely busy and often appeared to be overwhelmed by their administrative load, which the students perceived to take up a large amount of their time. The volume of paperwork was seen to be *'never ending'* by some of the students. As a consequence, like their colleagues involved in Stage 1 of the project they recognised that the RNs' administrative responsibilities left them little time to engage with the residents during the performance of activities such as medication rounds. As student 4 suggested:

> *I don't think they are doing it to be rude or horrible, it is just how it is … They don't have time and you feel really mean because the carers are there spending lots of time and you are just in and out to do drugs.*

The students' comments suggest that in some ways they were overwhelmed by the RNs' level of responsibility. However, despite the demands made on the RNs in most facilities the students appreciated the time they made for them. As student 6 reported *'as busy as they are they all make time for the students ... they have got their own jobs and the RCSs to fill out still, as well'.*

The insight the students gained during their placement allowed them to reconsider their understandings of the role of the RN to a point where they saw it as:

- very complex;

- carrying a great responsibility not only for a large number of residents but also for the work of the ENs and PCAs;
- reliant on the assessment skills of the ENs and PCAs;
- requiring a broad knowledge base; and
- requiring a capacity to engage in clinical decision making in the absence of on-site medical support.

In one RACF where the 'log' revealed that students worked very little of the time with RNs, the students understood that this was not for want of trying on the part of this nurse. For example, student 18 reported:

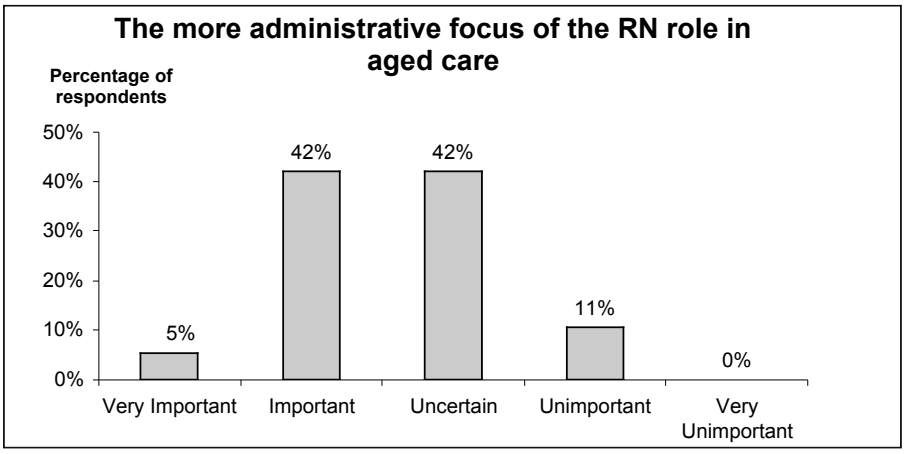
> *We had one RN pretty much for this whole place. And because there's 130 people here, she's always running around doing all the things she has to do. She's in charge of ordering everything in. So a lot of the times she's not on the floor doing a lot of the stuff but she's on call.*

At the same time, the students in this facility were aware of the RNs' frustration with the way her role was structured. Student 17 recounted:

> *I think the RN realises that there is a shortage of RNs and she feels bad, she comes and says 'I feel bad, I haven't seen you today and we haven't done stuff'. It's evident. She knows.*

The evaluation (Figure 32) completed by students at the completion of the practicum further highlighted the significance of the RNs administrative focus on influencing the students' intention to work in the area following graduation. As illustrated below, around 50% of the students considered this to be very important/important negative in influencing their decision making.

Figure 32: The degree to which the more administrative focus of the RN role would affect students' decision to work in aged care



Summary

The findings of Stage 2 of the Building Connections in Aged Care report highlights the effectiveness of implementing the recommendations outlined in Stage 1 of the project. A significant positive impact on students' experiences of placement within residential aged care occurred and possibilities for developing quality clinical placements within the sector uncovered. Of particular importance to developing quality placements for undergraduate students, the findings have demonstrated that appropriate staff preparation prior to students undertaking placement and comprehensive student orientation to the residential care setting is

crucial in creating a positive, supportive, teaching and learning environment. In addition, the importance of maintaining a high level of continuity between students and preceptors was found to be a crucial factor in students feeling comfortable within the setting, developing a rapport with their preceptor and enhancing their capacity to develop competence. Students appreciated working with the same preceptors who could make informed decisions regarding their progress. Furthermore, benefits of students working within the one area for the majority of their placement enabled them to feel they had made a positive contribution to the care team and were more confident to make decisions regarding issues of resident care. When continuity of area was interrupted, by students rotating to different wings of the facility, such benefits were not apparent.

Data revealed that students also worked with PCAs and ENs during the course of their placement to varying degrees, dependent on the individual RACF. This raises a number of issues as to how students are adequately supervised in these situations and in particular how PCAs are prepared to work with undergraduate students. Students undertook a range of nursing activities which varied across the six facilities. The variation in activities was partially related to with whom the students worked. Students who worked more with PCAs, spent markedly less time engaging in RN related activities. This raises an issue for future concern as to the quality of clinical experience received by students dependent on the level of staff supervision.

As an added dimension to students' experience of placement perceptions of working with the elderly were elicited. Data revealed that an overlay of ageist serotypes and language were evident, with students experiences of dealing with older people and old bodies being, at times, confronting for some but not others. Differences in perceptions between students may be influenced by previous work history or exposure to aged care prior to placement. Importantly, 95% of students enjoyed working with elderly residents. Overall students' perceptions of working in aged care were also found to be influenced by issues of salary disparity and the administrative workload of RNs. These workforce realities were found to have an impact on students' attitudes towards perusing a career in aged care.

6. Discussion, evaluation & recommendations

The report of Stage 2 of the Building Connections in Aged Care project addresses the experiences of three groups of RN/EN preceptors and the student nurses they worked with while on placement in six residential care facilities.

In Stage 1 of the project the aim was to scope the field to identify issues, which either facilitate or impede teaching and learning. Stage 2 of the project had a focus on implementing the key recommendations made in the Stage 1 report and to investigate possibilities for developing quality clinical placements in aged care.

As outlined previously, a primary focus for preceptors' in Stage 2 was to improve induction processes and enhance the level of continuity with students to facilitate teaching and learning in practice. Additionally, the research team sought to further investigate the activities students engaged in while on placement in aged care, as well as who they worked with.

The outcomes of preceptors' attempts to implement the Stage 1 recommendations have been documented in some detail in section 5 of this report. Section 6 addresses additional evaluation of the data collected from both students and preceptors, provides a summative account of the issues raised and makes recommendations for Stage 3.

Furthermore, following a meeting with the Project Steering Committee on 10 August 2004, and subsequent discussions with the Directors of Nursing of the six RACFs, it was agreed that Stage 3 of the project would repeat Stage 2 with a third cohort of students. The reasons underpinning this decision are apparent in the discussion that follows.

Recruitment into residential aged care

Change in student attitude to working in the sector

Given the potential impact on the recruitment and retention, a key focus of this project was to develop strategies, which would have a positive impact on student attitudes to working in the sector. This was important because it is well documented that student nurses have a negative perception of working in aged care (Happell 2002), which in turn impacts on the recruitment of nurses into the sector.

Consistent with the Stage 1 recommendations, Stage 2 of the project implemented a number of strategies to address problems with orientation and continuity. As the findings presented thus far highlight, the implementation of these strategies had a major impact. This was no more obvious than the positive change in student attitude to working in the sector.

To evaluate the impact of participation in the project on career intentions, students were surveyed to determine their attitude to working in aged care as a registered nurse:

- prior to commencing the placement;
- after 4 days in practice and following orientation to the RACFs; and
- at the end of the placement.

As evident in Figure 33 below, analysis of the student responses to the question ***'Following graduation would you consider working in aged care'*** demonstrates that the implementation of the Stage 1 recommendations had a significant positive impact on students' stated career intentions. For example, on commencement **55%** of students indicated they would **possibly not/definitely not** have an interest in working in aged care following graduation. However, this sentiment changed such that:

- at the end of week one, following orientation to the facilities, **80%** of students indicated a possible/definite interest in working in aged care following graduation; and
- at the completion of the practicum **90%** of students indicated a possible/definite interest in working in aged care following graduation.

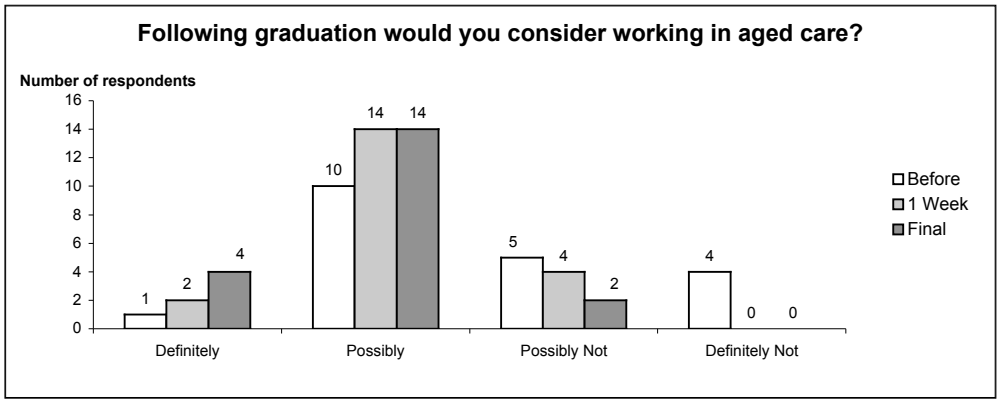
The evaluation also demonstrated a decrease in the number of students who held definite views that they would not work in aged care following graduation. For example;

- prior to commencing the placement, **20%** of students indicated that they would definitely not work in aged care following graduation;
- on completion of the practicum **no** students indicated that they would definitely not work in aged care following graduation. Of note, as demonstrated in Figure 33, this shift in sentiment occurred following orientation to the facilities.

At the same time there was a concurrent shift in sentiment of students who indicated they would definitely consider working in aged care following graduation. For example,

- on commencement **5%** of students indicated a definite intention to work in aged care following graduation
- on completion **20%** of students indicated a definite intention to work in aged care following graduation.

Figure 33: Changes in student attitude to working in aged care



The positive change in student attitude exceeds the Key Performance Indicators (KPI) benchmark set at the commencement of the project which stated that —70% of student participants indicate an interest in working in aged care following graduation.

These findings stand in contrast to Stage 1 where there was minimal improvement in student attitudes to working in the sector following graduation. In this stage the shift in sentiment changed from 50% of students nominating that they would consider working in aged care on entry, to 64% at the completion of the practicum. This further highlights the significance of the improvement achieved in Stage 2 of the project.

Differences between stage 1 and stage 2 student cohorts

In this project it must be acknowledged that the Stage 2 student cohort was somewhat different to the cohort involved in Stage 1.

The Stage 1 students participated in a three-week hospital practicum prior to working in the RACFs. In contrast, the Stage 2 students had no substantive prior experience in practice, apart

from the ten observation days in hospitals and RACFs, organised in the first year of the Bachelor of Nursing course.

Given this difference in the cohorts, it is important to further investigate if prior experience in an acute hospital has a significant impact in influencing student career intentions. To this end we think it is appropriate to replicate the project with a third cohort of students to investigate if prior experience in a hospital impacts on student perceptions of aged care and related career intentions.

Recommendation 1

> **That Stage 2 of the project be replicated with a third cohort of students who have prior experience in acute care hospitals, to determine if participation in Stage 3 of the project results in a similar positive shift in attitude with respect to students' intention to work in aged care.**

Future evaluations/projects

In many respects Stage 2 of Building Connections raises as many questions as it answers. In truth, it has merely begun the process of investigating the issues that impact on the capacity of RACFs to support the education of student nurses in ways that will encourage them to return to the sector following graduation. As such, the following sub-section of this report provides a series of recommendations for future research to be conducted in this area.

Evaluating sustainability

A key focus of the Building Connections project is to develop sustainable support structures for student nurses on placement in RACFs. Consequently, it is imperative to assess the sustainability of improvement, demonstrated in Stage 2, as a result of the six RACFs' involvement in the project.

The fieldwork for Stage 3 of the project will finish in October 2004 so it is reasonable to evaluate the facilities and the experiences of students on placement within them in 2005. The evaluation should be developed from the Student Nurse Initial Evaluation Part A and Part B (Appendices 2 & 4) and the Student Nurse Final Evaluation (Appendix 6). The conduct of this evaluation with second year nursing students (n=40) on placement within the six RACFs, during semesters 1 and 2 of the 2005 academic year, will provide further evidence of the sustainability resulting from our efforts to develop quality clinical placements in aged care.

Recommendation 2

> **That a follow up evaluation be conducted across Semesters 1 and 2 of the 2005 academic year, with second-year nursing students (n=40), on placement in the participating RACFs to determine if the students' attitudinal change to working in aged care following graduation is sustained.**

Evaluating impact

To further evaluate the impact of the research, an evaluation should be conducted with students who undertake clinical placements in RACFs that have **not** been involved in the Building Connections project. This evaluation will enable a determination to be made of any change in the students' attitude to working in aged care as a result of this experience. The findings of this evaluation can then be compared with the evaluation conducted in the

participating RACFs in 2005 (outlined above in Recommendation 2). The comparison will provide further evidence of any impact on student attitudes/experience as a consequence of the RACFs involvement in the research. As in the previous case, for consistency this evaluation should be developed from the Student Nurse Initial Evaluation Part A and Part B (Appendix 2 & 4) and the Student Nurse Final Evaluation (Appendix 6).

Recommendation 3

> **That evaluations be conducted across Semesters 1 and 2 of the 2005 academic year, with student nurses (n=40—60) on clinical placements in RACFs not previously involved in the research. This will allow a determination of any change in their attitude to working in aged care following graduation.**

Evaluating transferability

It is probable the findings of the Building Connections project have high-level transferability across a range of residential aged care contexts. The involved facilitates are generally representative of RACFs because they include private and charitable providers, are located in both rural and urban environments, vary in size and the services they offer and have had limited prior engagement with the university sector. Similarly, like many aged care contexts, the RACF partners involved in this project have three to four undergraduate nursing students on clinical placement at any one time.

Nevertheless, it must be acknowledged that the transferability of the strategies developed to facilitate quality clinical placements in aged care to other RACFs both within rural and remote regions of Tasmania, or indeed in other Australian States has yet to be tested. With respect to the latter, because the project has been conducted in only one State of Australia, the impact that regional variations may have on the applicability of this approach in developing quality clinical placements in aged care cannot be determined

Therefore it is advisable to expand the project into other RACFs to further test the transferability of this approach in facilitating a positive shift in students' attitude to working in the sector. Expanding the breadth of the research will also facilitate further refinement of this approach to developing quality clinical placements in aged care and allow a more accurate evaluation of its applicability across a range of contexts.

Recommendation 4

> **That the Building Connections project be replicated in other areas of Tasmania to further investigate the applicability of this approach to developing quality clinical placements in aged care.**

Recommendation 5

> **That the School of Nursing and Midwifery, University of Tasmania collaborate with other Schools of Nursing to replicate the Building Connections project in at least two other Australian states to further investigate the applicability of this approach to developing quality clinical placements in aged care.**

Other issues impacting on recruitment

This report began by locating the Building Connections project within the wider aged care milieu, which outlined the range of issues that impact on the aged care workforce and the

recruitment and retention of nurses into the sector. It is noteworthy that in both the context of the research group discussions and the final project evaluation, the students identified disparities in salary rates between aged care and other areas of nursing as a significant disincentive to working in the sector. The Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:223), referred to previously, notes the 'disparities of pay for aged care nurses compared to acute care nurses can act as an obstacle to recruitment and retention of skilled staff in the sector'. Similarly, as demonstrated in section 5 of this report, 70% of students rated this issue as **important/very important** in determining their future career options. Comments made in the final student evaluation further highlight the impact of lower salaries on student career intentions. They include:

- *The lower salary and increased responsibility (less support) concerns me greatly.*
- *The only thing that would keep me out of aged care is the lower salary.*
- *At the end of my nursing career I may consider it. At the moment the pay is not enough and the work is not as beneficial to broadening my nursing knowledge.*

These findings suggest that structural issues within aged care also play a significant role in influencing student decision making with respect to choosing aged care as a career option.

Furthermore, as outlined previously, many students found the responsibilities associated with being a RN in aged care somewhat overwhelming. They struggled to understand the RN role given it did not involve, as one student noted, '*a lot of hands on with the residents'*. Rather the RNs appeared to be consumed by administrative activities. These sentiments mirror those reported by students in Stage 1 of this project, as well as the Making Connections project (Robinson et al. 2002). As stated in Stage 1, if the students do not perceive the role of a registered nurse in aged care to be congruent with their perception of their role following graduation, this raises a fundamental obstacle to encouraging new graduates to work in the sector.

It is noteworthy that this issue is raised by yet another group of students. This finding further highlights the importance of funding a national project, recommended in the Stage 1 report, to examine the role of the registered nurse in aged care with a specific focus on his/her involvement in the provision of nursing care to residents and the supervision of unregulated workers.

RACF Orientation for Students — 3 Preparatory Stages

The Stage 2 findings illustrate the importance of students receiving a thorough and well-planned orientation to the RACFs so to establish quality clinical placements in aged care.

The students' comments clearly indicate the significance associated with feeling welcome in the facilities and the importance of the facility staff being organised and prepared for their arrival. Indeed, an explicitly welcoming attitude is critical to giving students an impression that their presence is highly valued by RACFs staff. The importance of this is reinforced by the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:224-5), which notes, 'an unsupportive environment [has] often been cited as [a] reason for nurses leaving aged care or not being willing to enter this area of employment.'

With respect to orientation, the value of informing all staff regarding the imminent arrival of students cannot be overestimated. The symbolic importance of being highly organised and prepared indicates to students that the RACFs consider them to be important and significant members of the team. The allocation of resources to provide preparatory information and programs reinforces this impression and sets the students up for a positive experience. As one student commented, orientation provided a *baseline for the whole experience*.

The significance of comprehensive preparation, as well as an explicitly welcoming approach from RACF staff is evident in the students' change in attitude after just four days in practice. As outlined previously, the project evaluation revealed a shift from 55% of students who indicated an interest in aged care as a future career option, to 80% following orientation.

The findings also highlight the importance of RACFs and Schools of Nursing working closely in the organization of clinical practicums, if aged care staff are to provide effective induction and orientation processes.

The three preparatory stages prior to students undertaking clinical placements in aged care

The findings of Stage 2 of Building Connections reveal **three stages** that that can be used as a Guideline to prepare RACFs for nursing students.

Stage 1 — Supply of information relating to students

In preparation for the students' arrival in the RACFs, Schools of Nursing should provide facility staff with an overview of the students' relevant course of study as well as information on their:

- names and starting times in practice;
- previous experience in practice; and
- learning objectives and associated documentation.

Stage 2 — Identification of key stakeholders and formation of a preceptor group

It is essential that the interest in students be widespread among key stakeholders within the facilities, most importantly with those nurses who will work with students as preceptors. As such, to prepare the facilities for students the RACFs should:

- identify a staff member who will liaise with the RACF's Director of Nursing to prepare and coordinate the orientation of students;
- identify preceptors who are keen to work with students; and
- form a group of interested preceptors to facilitate the student practicum and develop orientation resources.

Stage 3 — Preparation of staff and development of resources

In consultation with the RACF's Director of Nursing, the members of the preceptor group should:

- disseminate information regarding the imminent arrival of students to **all** facility staff;
- conduct formal and informal discussions with **all** staff regarding the students' role and prior experience and learning needs;
- target key staff (PCAs) who will work with students under the supervision of RNs;
- develop information packages for students that address RACF routines and resident needs, as well as general information relating to facility resources and procedures;
- develop rosters so students have the opportunity to both work with their preceptors and work in the same area of the facility over time; and

- promote students to staff as being very important to the facility and encourage them to be as welcoming and supportive as possible.

Recommendation 6

To achieve quality clinical placements in aged care, RACFs should implement the three stages of preparation prior to students undertaking clinical placements in aged care, to ensure:

1) **appropriate information regarding students is available within the facilities;**
2) **key stakeholders are recruited to support students, and;**
3) **facility staff and resources are appropriately prepared.**

The project findings suggest that it is possible to change the prevailing negative attitude that most students have of aged care, in circumstances where RACFs implement the three stages of preparation outlined above. In a sense, the implementation of these stages can be regarded as the cultural and organisation prerequisites to setting up a quality clinical placements in aged care.

Continuity between students and preceptors

The findings demonstrate that a high level of continuity in the relationship between preceptors and students has multiple benefits and is implicit in the development of quality clinical placements in aged care.

Interestingly, the preceptors report that working with a student over time made the role of preceptor more satisfying – a finding also supported by the Making Connections in Aged Care project (Robinson et al. 2002). Furthermore, as has been outlined previously, continuity between student and preceptor enhances the possibilities for building rapport, as well as the preceptors' capacity to assess changes in student competence and confidence, which in turn empowers them to structure appropriate teaching and learning experiences in response.

It is also apparent that students appreciate working with preceptors who can make what they consider to be informed decisions regarding progress. From the student comments it is evident that continuity and the associated increased capacity of preceptors to make accurate assessments of competence, enhances their credibility. In other words, in these circumstances students are more likely to take direction from preceptors, positively respond to critique and judge the practicum a worthwhile learning experience. In this way facilitating continuity between the students and preceptors enhances the overall experience of students and as such can be considered a positive strategy to facilitate student interest in working in the sector.

Additionally, the findings indicate that continuity with preceptors, combined with working in the same area over time, enhances students' capacity to make a positive contribution to the care team. In turn, this facilitates their acceptance within the team and the positive nature of their experience. This is no more apparent in circumstances where preceptors protect students in the context of staff shortages, where there can be a powerful imperative to use students as a 'pair of hands'. In this kind of situation having a good knowledge of the student allows preceptors to make informed decisions regarding what might constitute legitimate expectations and assists them to take action to protect students in the context of resource shortages. Similarly, working in the same area over time gives students an opportunity to get to know residents and their care needs, which in turn assists in the development of clinical competence.

Developing rosters well in advance and matching individual students with their preceptors is essential if an appropriate level of continuity between student and preceptor is to be achieved. This kind of planning is important in RACFs where most nurses work part time and their

rosters are defined by the requirements of shift work. Despite the limitations associated with rosters and part-time work, with forward planing in it is possible to achieve a satisfactory level of continuity between the students and preceptors. What is important to acknowledge is that continuity between the two significantly enhances the overall experience of students and as such can be considered a core component of quality clinical placements in aged care. This is no more evident in the Stage 2 project, which highlighted that students have a far more positive relationship with their preceptors compared to their colleagues involved in Stage 1.

However, while the findings do indicate the benefits of continuity, the data collection processes employed in Stage 2 of the project did not allow the extent of continuity between students and their preceptors to be accurately quantified. It is important to quantify what level of continuity between preceptors and students is necessary to promote a quality engagement and effective teaching and learning. This will allow for the establishment of a benchmark against which RACFs can judge the degree to which they are realising a quality clinical placement for students.

Recommendation 7

In order to develop quality clinical placements in aged care:

1) **RACF staff should develop rosters so students have the opportunity to both work with their preceptors over time;**
2) **rotations through areas in RACFs should be minimised to allow students to gain familiarity with both the context and residents; and**
3) **the rotation of students to different areas of RACFs should be the subject of negotiation between preceptors and students.**

Recommendation 8

The extent of continuity between individual students and their preceptors should be determined in Stage 3 of the project to begin the process of developing a benchmark for continuity in quality clinical placements in aged care.

Student activities & supervision

Investigating supervisory practices

A key finding of Stage 2 of the project is the significant differences between the six involved RACFs. While this is most obvious in their size, location and staffing profiles, the 'Supervision and Placement Activities Log' revealed that in the context of aged care placements, students can engage in a very different mix of activities in one facility compared to another.

Analysis of the data reveals that different staffing profiles have a significant impact on the activities in which students engage. A case in point is RACF 5, which employs the most PCAs, and where students spend on average 25% of their time working with carers. As a result their involvement in activities of daily living (27%) in this facility was more than **double** that of students located in other RACFs (11%), where they spent considerably less time working with carers. This situation reflects a reality in aged care where PCAs provide most general care to residents and, as outlined above, where RNs perform a more administrative role with a concurrent focus on the administration of medications and performance of procedures.

Students working with supervised practitioners

Of note, analysis of the Supervision and Placement Activities Log reveals that on average students worked either directly or indirectly with PCAs on average around 12.5 % of their time in practice. At the same time students spent on average around 17% of their time working in practice either directly or indirectly with ENs (with a range from 0% to 37.5%). In both these circumstances the regulatory requirements governing nursing mean that students must be supervised by an RN.

While students working with PCAs and ENs may be a reality in aged care, we currently have little or no information on:

- the strategies RNs employ to ensure adequate supervision;
- how they monitor students' work with PCAs and ENs; or
- what activities they undertake to ensure quality teaching and learning outcomes.

The lack of information regarding the structures and processes to support the supervision of students in aged care suggest that it is essential to investigate this issue further. This is especially important given the increasingly administrative and procedurally focused role of RNs working in the sector.

Recommendation 9

> **That the structures and processes employed by aged care nurses to supervise students whilst working either directly or indirectly with PCAs and ENs be investigated as a key focus of Stage 3 of the project.**

Preparing PCAs to work with students

It is evident that students do spend on average up to 25% of their clinical placement in aged care working either directly or indirectly with PCAs, and that as demonstrated in Stage 1 of this project, this can be a less than rewarding experience. Moreover, the findings of Stage 1 of the project revealed that students struggled to accept that working with these staff was legitimate in the context of their training to become registered nurses.

Following the Stage 1 recommendations, in Stage 2 of the project a range of strategies were implemented to prepare both students and PCAs to work together. These included

- School of Nursing staff meeting with students to discuss the issue of working with PCAs prior to their entry into the facilities;
- Preceptors targeting appropriate PCAs to work with students; and
- Holding formal and informal meetings with PCAs to discuss issues around working with students and facilitating teaching and learning in practice.

These strategies appear to be effective because the students reported far more positive experiences when working with PCAs in Stage 2. However, the preparation of PCAs to work with students is an issue that needs further investigation. While the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004) recommends the upgrading of PCA training, it's reasonable to suggest that preparation of PCAs to support students in clinical placements should be integral to this process. Within a contemporary aged care environment this must be an important development given the inevitability that student nurses on placements will work with PCAs in the provision of resident care.

Recommendation 10

> **That consideration be given to investigate strategies to prepare PCAs to support nursing students on placement in RACFs as a component of Certificate III or IV qualification.**

Supervisory tensions for preceptors

It must be recognised that in their role as preceptors both working with and supervising students, aged care nurses face multiple tensions, not least of which is related to workloads. Comments made by preceptors in the evaluation in response to the question, 'What are the least enjoyable aspects of being a preceptor?' highlight the tensions between teaching and practice. They include:

- *Only issue … is needing a little extra time out from our routine duties.*
- *Busy, busy, busy.*
- *Trying to balance their learning needs with activities and situations on the floor when time was an issue.*
- *Never seems to be enough time.*
- *Not being able to teach enough, i.e. not enough hours in the day and working on an extremely busy wing.*
- *Workload, unable to do other tasks for three weeks, dealing with some personality conflicts.*
- *Double pace when they are not around to catch up on tasks not undertaken with students but necessary for the work on shift. Always thinking for two people: yourself and the student.*

It is an issue also appreciated by students who made numerous comments that the RN preceptors were extremely busy and often appeared to be overwhelmed by their administrative responsibilities. These findings suggest that the capacity of aged care nurses to effectively supervise students when they work with PCAs and ENs is an issue, which needs further investigation in Stage 3 of the project.

Recommendation 11

> **That Stage 3 of the Building Connections in Aged Care project investigate tensions between the nurses' role as preceptors in supervising and teaching students and their role in ensuring the provision of quality resident care.**

Student activity in RACFs

Student involvement with residents

The findings of Stage 2 demonstrate that students have varied interactions with residents. While some students struggled with the unfamiliarity of working with older people others appeared comfortable and at ease. It is also apparent that the reality of aged care and the situation of residents has a significant impact on students perceptions of aged care and more than likely influences their decision making with respect to working in the sector following graduation. These issues warrant further investigation in Stage 3 of the project, to develop a better understanding of resident involvement with students and how this impacts on the students' experience of aged care and their perceptions of the sector.

Recommendation 12

> **That Stage 3 of the Building Connections in Aged Care project investigate resident involvement with students and how this impacts on the students' experience of aged care and their perceptions of the sector.**

Involvement in the physical assessment activities

In terms of student involvement in different activities, analysis of the Supervision and Placement Activities Log reveals that they were primarily involved in medication management (22.7%), hygiene activities (13.1%) and activities of daily living (11.4%). However, no data was collected on their involvement in the physical assessment of residents. The lack of reference to physical assessment needs to be addressed because this can be considered a core activity in RACFs, and a key function of aged care nurses as it directly informs not only the provision of care, but also the Resident Classification Scale (RCS) documentation and facility accreditation. This means the 'Supervision and Placement Activities Log' must be revised in Stage 3 of the project to facilitate the collection of data on students' involvement in the physical assessment of residents, as well as who it is that supervises and instructs students in this activity.

Recommendation 13

> **That data be collected in Stage 3 of the project to determine the extent of students' involvement in the physical assessment of residents and who it is that supervises and instructs students in this activity.**

Differences between high and low care

It is also apparent that we have limited information on the differences in student experiences when they work in 'high care' areas as opposed to 'low care' areas. Similarly, the impact on RN supervisory practices when students are placed in high care environment as opposed to low care environments is also unknown.

Recommendation 14

> **That data be collected in Stage 3 of the project on the activities undertaken by students in high care and low care in order to better understand how this impacts on their clinical placements and the effects for RN supervisory practices.**

Building capacity among aged care nurses

A key focus of the Building Connections project is to build capacity among aged care nurses, particularly in relation to their role and function in working as preceptors with students. As indicated in the Figure 34 and Figure 35, in both Stage 1 and Stage 2 of the project, participation in the research had a very positive impact on the preceptors' knowledge and confidence. Certainly, the findings of Stage 2 also demonstrate that according to the students, the nurses were highly effective in their role as preceptors.

Figure 34: Improvement in knowledge of being preceptor

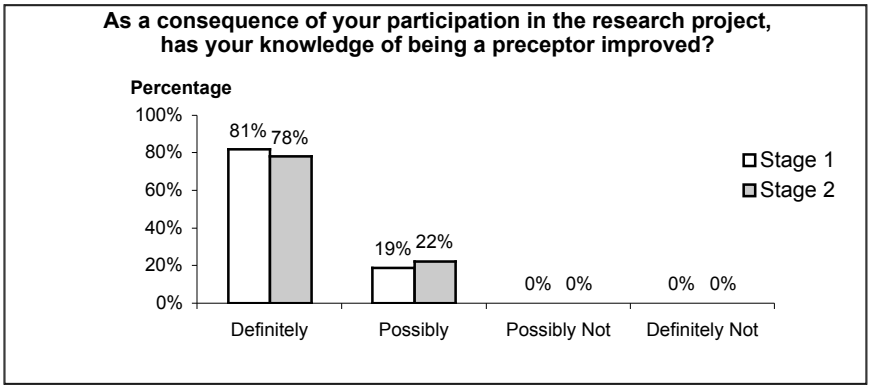
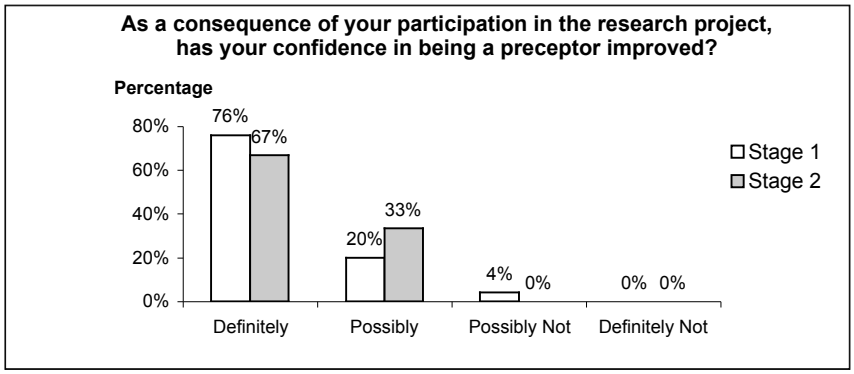


Figure 35: Improvement in confidence as a preceptor



The project evaluation demonstrates that both Stages 1 and 2 of the project achieved the second key performance indicator (KPI), which stated that — RN and EN mentors/preceptors reported increased capability/confidence to act as mentors/preceptors and to effectively support undergraduate students on clinical practicums in aged care.

Facilitating professional development to support students

Other aspects of the evaluation further demonstrate that participation in the research was a successful exercise in professional development.

Facilitating professional development among RACF staff is especially pertinent to a key aim of the Building Connections project:

- To build capacity among the aged care nursing workforce in the participating RACFs with the intent to develop the facilities as key sites for teaching and research.'

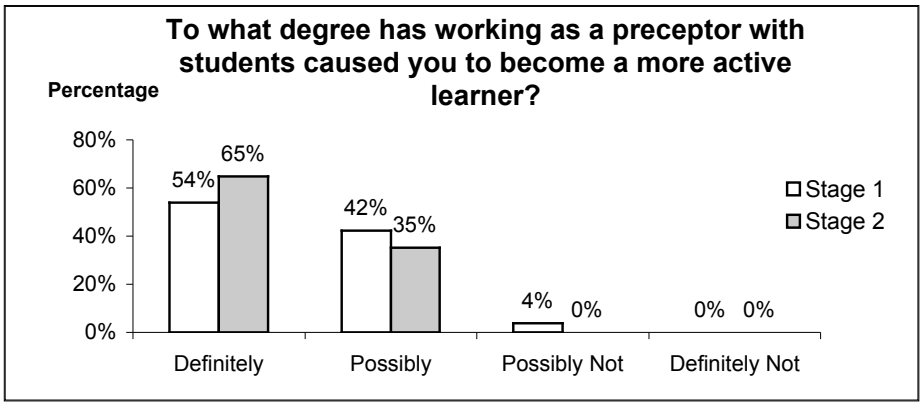
As stated previously in Section 1 of this report, this aim is consistent with the intent outlined in the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004:285) and its' calls for closer links between the aged care and university sectors.

To achieve this aim it is imperative that RACF staff are actively engaged in developing their knowledge, understanding and practice as nurses. Within the context of this project, where the nurses had the opportunity to discuss and critically reflect on their practice, the presence of students provided a crucial stimulus. The importance of students in sustaining and developing learning organisations is well recognised, and they are acknowledged as the life-blood of public teaching hospitals.

In aged care the concept of teaching nursing homes (TNH) has been explored. These are nursing homes, which have affiliations with academic institutions, and offer synergies between clinical practice, education and research. Benefits associated with recruitment are identified, as well as professional development of staff and enhanced quality in the provision of resident care (Chilvers and Jones 1997). In many respects the six RACF industry partners involved in the Building Connections project function as TNHs, and this is evident in the findings, which reveal that the presence of students provides a critical stimuli for aged care nurses to become more active learners who critically reflect on their practice.

While comments made by the preceptors outlined previously, highlight this, the Stage 1 and Stage 2 project evaluations (Figure 36) further reinforce the benefits associated with aged care nurses working as preceptors with undergraduate nursing students.

Figure 36: Promotion of active learning among preceptors



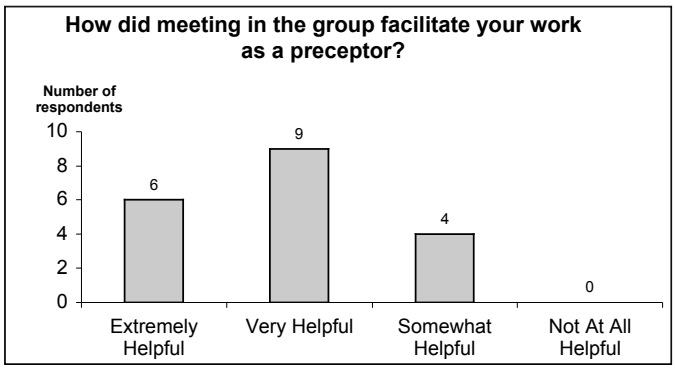
Comments made by preceptors in the Stage 2 evaluation further highlight the ways that students provide a significant impetus for aged care nurses to actively seek out new information regarding their practice. Typical comments made by preceptors include:

- *I now actively seek more information without delay, where before this was often postponed and forgotten about.*
- *I now research things more and ensure if I don't know something that I research it to provide info to students.*
- *To look back over things and to look things up and ensure you are teaching the correct things i.e. things change – methods and techniques.*
- *Looking up information for the students and preparing sheets on different topics stimulates you to continue learning.*

However, it must also be appreciated that students alone will not provide the impetus for such developments. The teachers, in this case, aged care nurses, must also be professionally engaged and receptive to the challenges that students inevitably raise. The death of a learning

organisation is defensiveness and unyielding resistance to change and new ideas. In this sense the nurses' involvement in the research provided the necessary structure and process where the preceptors could realise a potential to become more active learners and engage in critical reflective processes. Such findings were also evident in Stage 1 of the project, which highlighted the importance of aged care nurses having an opportunity to meet to discuss practice issues, both within their facilities and with colleagues from other RACFs. The Stage 2 project evaluation also demonstrated that the nurses found participation in the research a valuable experience (Figure 37).

Figure 37: Preceptors – value of research meetings



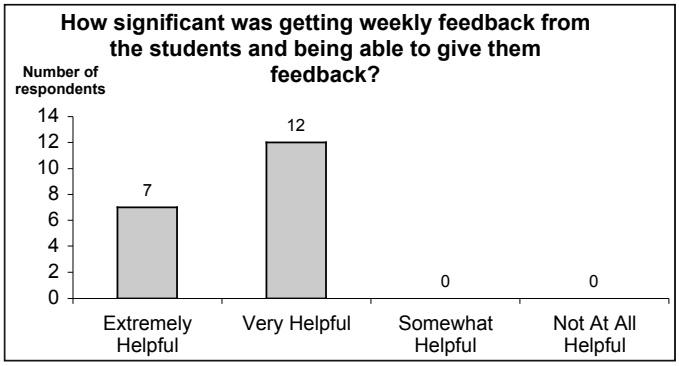
Comments made in the evaluation further highlight the significance that the preceptors associated with having the opportunity to come together to share experiences, supporting each other, and network. In this sense, participation in the research meetings functioned not only as a capacity building exercise, but also as an effective strategy to break down the nurses' isolation within RACFs. Bringing aged care nurses together in this kind of discussion group is a very effective strategy to facilitate network formation and promote professional engagement. The following preceptor comments illustrate this:

- *[In the research] I was able to share ideas, able to provide support for each other, developed links between facilities.*
- *It made me realise that all preceptors felt and experienced the same issues.*
- *Having interaction with similar situations was helpful in as much as it was comforting to know that everyone was questioning and sharing ideas.*
- *Gives confidence 'your doing ok', networking.*
- *Made us realise what was happening in other facilities and following up how the students felt about their placements.*

With respect to the RNs' role in the supervision of students, as outlined previously, the positive attitude of the preceptors was a significant influence on the students' experience. The students' accounts highlight the preceptors' willingness to involve students in activities and to take the time to demonstrate procedures in order to prepare them. Such actions are indicative of the preceptors' commitment. Like the comments made by students involved in Stage 1, the importance of preceptors having a positive volition when working with students is most obvious in the students' comments on their negative experiences of working with nurses not involved in the project. The nature of these accounts indicates that participation in the research meetings had a powerful influence in shaping the nurses' attitudes and understandings of their role as preceptors. Indeed, the evaluation illustrates that the preceptors did indeed believe that their knowledge, confidence and skill in working as a preceptor had greatly improved as a consequence of their participation in the research. Such findings highlight the importance of supporting nurses to develop their role and that the use of a participatory approach, such as that adopted in this project, is highly effective.

Similarly, as Figure 38 highlights, getting feedback from students as a part of the Fourth Generation Evaluation method was deemed very helpful in assisting the preceptors to facilitate teaching and learning.

Figure 38: Preceptors - value of the research feedback loop



Comments made in the evaluation further illustrate this point:

- *[Feedback was] helpful with validating your teaching skills.*
- *Although we communicated well with our students some useful comments arose from feedback and it provides an avenue if students are unwilling to speak to staff. [It was also good to] hear about other facility's concerns.*
- *Feedback from the students was helpful as a guide in my role a preceptor – if there were areas that we needed to cover or do with them* [students]. *Giving the students feedback – they have a better idea how they are going – changes that we may need to make.*
- *Feedback is great – you know if you're on the right track for what the students need.*

It is important to recognise that the benefits of such developments are cumulative and that nurses' involvement in these processes should be ongoing. This is especially important in aged care, where as Stage 1 findings highlighted that aged care nurses work in relative isolation in a context characterised by a limited professional engagement or networks into the wider aged care sector. The Review of Pricing Arrangements in Residential Aged Care (Hogan 2004) raises this concern when it notes that aged care nurses lack educational opportunities and it puts the view that aged care providers should 'grow' their own staff through the use of innovative educational and training avenues.

While the Australian Government response to the Review of Pricing Arrangements in Residential Aged Care included the announcement of additional funding of $101.4 million over four years to further assist in the attraction, retention and training of aged care staff, these additional funds included the provision of an additional 400 undergraduate nursing places to complement the CACNSS. However, it is arguable that additional funding should also be provided to augment the availability of scholarships, in order to create linkages with aged care systems to support the aged care workforce to undertake educational opportunities within the sector in order to build capacity to support scholarship holders appropriately. Indeed, the findings of Building Connections suggest that without additional support the aged care sector lacks capacity to provide students with effective clinical experiences, resulting in some risk in the provision of scholarships without adequate support systems in place.

Recommendation 15

That Australian Government funding be applied to create linkages with aged care systems to support the aged care workforce to take up educational opportunities within the sector to build capacity to support

CACNSS holders and thereby develop quality clinical placements in aged care.

Conclusion

This report addresses the findings of Stage 2 of The Building Connections in Aged Care Project and focuses on the implementation of key recommendations made in the Stage 1 report. In addition, an overarching aim of the second stage of this project was to investigate the possibilities for developing quality clinical placements for undergraduate nursing students within aged care. It is essential to recognize that this project is located within an industry which faces significant challenges. The ongoing problems surrounding recruitment and retention of appropriately qualified nurses; the part-time nature of the workforce; the context of limited professional engagement within which aged care nurses work and the lack of an evidence base for training and curricula in aged care serves to create an environment where, in the past undergraduate nursing students have found themselves grappling with the realities of aged care nursing.

Despite such challenges, this research has successfully bought about change not only in students' attitudes towards working in an aged care environment but also in preceptors' approach towards preparing for and working with undergraduate students. As a result of collaboration between the RACFs and the Tasmanian SNM a cohesive infrastructure of support was established to facilitate quality clinical placements for students. Integral factors in this infrastructure were, adequate preparation of RACF staff prior to student arrival, comprehensive student orientation to the RACF and a high level of continuity between students, their preceptors and work areas. The ability of this research to encourage students to reconsider and challenge their understandings of aged care nursing is a testament to the success of the fourth generation evaluation approach and ultimately the collaborative effort adopted between the six RACFs and the university.

The collaborative approach between the Tasmanian SNM and the RACFs, has demonstrated that the calls for closer links between aged care and university sectors (Hogan 2004:285) is not only possible, but may be highly successful in forging a future where undergraduate students are more likely to consider aged care as an attractive career option. Beyond the six RACFs involved in this research, it is essential that other industry leaders be cognizant of the benefits of tertiary collaboration, and play a role in ensuring quality clinical placements are developed and consistent across the industry. From this perspective, it is imperative that this research be extended to ensure transferability and sustainability and consequently attract both state and federal attention to develop this evidence base within aged care.

7. Appendices

Appendix 1: Methodology: Fourth generation evaluation

Methodological Approach

The project utilised a 4th generation evaluation methodology (Guba and Lincoln 1989:72-74). This involved the formation of three groups of registered nurse preceptors and three groups of student nurses on clinical placements in the six RCFs. This approach was employed to facilitate communication (McGuiness and Wadsworth 1991) between the students and their preceptors because previous research has demonstrated this process to be very effective in facilitating teaching and learning in practice (Robinson et al. 1999).

To implement the method, students and preceptors met in separate, parallel groups on a weekly basis throughout the 3-week practicum. Sessional project officers employed by the School of Nursing & Midwifery participated in both student and preceptors groups in each RCF and in the research group was structured according to a series of ground rules Giroux, (1988:72) based on the assumptions that all members:

- have an equal right and opportunity to speak;
- respect each other's right to speak;
- have a sense that it is safe to speak; and
- that ideas raised in the context of discussion are both tolerated and are subjected to 'rational' critique.

Central to this process is the development of the inclination to trust each other, to value the sharing of different perspectives and an abiding commitment to improvement (Giroux 1988). Inevitably, participation in the research meetings involved the members of both groups engaging in a dialogue of their experiences of either working as a preceptor or being preceptored. Such meetings engaged the participants in a process of reciprocal dialogue which Young (1997:91) argues provokes consciousness raising and empowerment. She suggests that such encounters involve a 'give and take of discussion, [where] participants construct an understanding of their … lives as socially constructed, constrained in similar ways to that of others by institutional structures, power relations, cultural assumptions, or economic forces'. By engaging in this process, groups with common interests and concerns, like the students involved in a clinical practicum in a RCF, theorise their social account by 'moving back and forth between individual life stories and social analysis to confirm or disconfirm both' (Young 1997:91). Indeed, telling stories of practice is central to such dialogic encounters.

Storytelling has long been used as an educational technique, and more recently in nursing research (Bowles 1995; Nehls 1995; Kirkpatrick et al. 1997; Fassett and Gallagher 1998). Deconstructive therapists Michael White and David Epston argue that the very act of telling stories opens up possibilities for change because they 'dislodge[s] people from certain familiar and taken-for-granted notions about problems' (Epston and White 1992:13) and their personal implication in their construction. In research projects such as this, storytelling represents an important means by which habit, ritual and taken-for-granted understandings, being recast as the extra-ordinary and unfamiliar (Epston and White 1992). As such, the telling of stories of practice provides a vehicle through which we can re-interpret our experiences, (White 1992b:80), or in the case of this study, a vehicle by which students can

reconsider their work with elderly people in an RCF and a preceptor might reconceptualise their role teaching students. However, it is important to recognise that such stories must be told and retold, for they are always only 'partially tellable' (Howard 1991:192), indeterminate and characterised by a degrees of 'ambiguity and uncertainty… inconsistencies and contradictions' (White 1992b:82). This is important because the process of retelling of stories provokes critical reflection on experiences, issues and the conditions, which constrain and disable people from taking action to change their worlds. In turn this opens up possibilities for an alternative narrative to emerge as people separate themselves from dominant 'totalising' (White 1992a:125) stories that constitute their lives.

In the context of the project research meetings, both preceptors and students had an opportunity to participate in a process of telling and retelling their accounts of working with each other in the RCF. Through this process they created sets of research narratives that provoked them to critically reflect upon their situation and the constraining conditions. This was important because as Smyth and Shacklock (1998:6) suggest critical reflection upon the 'constraining conditions is the key to the empowerment 'capacities' of research and the fulfilment of its agenda'. As outlined above, critical reflection was facilitated by returning to the participants' case notes of the last research meeting, prior to the next. Returning to the notes was important because the reciprocity inherent in the free flow of discussion and narrative within research groups is enhanced by the participants being accorded a right of access to all data generated during the project. This opens up further opportunities to engage in collaborative theorising and the negotiation of meaning which 'helps build reciprocity' (Lather 1991:61) and by implication, possibilities for developing new understandings of teaching and learning in aged care.

Appendix 2: Student Nurse Initial Evaluation - Part 1

RESIDENTIAL AGED CARE PRECEPTOR PROJECT

Student Nurse Initial Evaluation May 2004

Part A

A) STUDENT INFORMATION

(Please circle appropriate response)

Region you are in practice? NW N S

Your Age? 18 -25yrs 26-30yrs 30-35yrs

36-39yrs 40-45yrs >45yrs

Have you previously worked in an aged care facility (i.e. as a carer etc)?

Yes No

If yes, in what capacity did you work?

Therapy assistant EN, ECA catering domestic staff

Other _____

Years working in aged care: < 6mths 6mths - 1yr 1- 5 yrs

6- 10 yrs >10yrs NA

Have you ever visited a relative in residential aged care facility?

Yes No

Prior to this clinical placement, what was the likelihood that you would consider working in aged care following your graduation?

Definitely Possibly Possibly not Definitely not

Part B

B) PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Did you request to come on clinical placement in an aged care facility (Circle appropriate response)

Yes No

Please explain you reason for answering yes or no

_____

_____

2. How would you describe your response when you found out you would be on placement in an aged care facility (Circle appropriate response)

Very happy happy neutral unhappy very unhappy

3. What sort of activities do you think you will be involved in while on prac in residential aged care (please specify)

_____

_____

4. Are you looking forward to working with elderly residents in the facility (Circle appropriate response)

Very happy happy neutral unhappy very unhappy

5. **In your previous clinical placements did you find the nurses you worked with:**
(Circle appropriate response)

(1) Very helpful	helpful	neutral	unhelpful	very unhelpful
(2) Very supportive	supportive	neutral	unsupportive	very unsupportive
(3) Very friendly	friendly	neutral	unfriendly	very unfriendly

6. Following graduation would you consider working in aged care
(Circle appropriate response)

Definitely	possibly	possibly not	definitely not

Appendix 3: RN/EN Initial Evaluation

UNIVERSITY OF TASMANIA

RESIDENTIAL AGED CARE PRECEPTOR PROJECT

STAGE 2

RN/EN Initial Evaluation May 2004

A) PARTICIPANT INFORMATION (PLEASE CIRCLE APPROPRIATE RESPONSE)

Is this your first time in the project	Yes		No	
Region?	NW	N	S	
In what capacity do you work in the aged care facility?				
	RN	EN	ECA	
Years working in aged care?	<1yr	1-5yrs	6- 10 yr	>10yrs
Years working in this facility?	<1yr	1-5yrs	6- 10 yrs	>10yrs
Experience as an RN,EN/ECA?:	<1yr	1-5yrs	6-10yrs	>10yrs
Your Age?	20-25yrs, 41-45yrs,		26-30yrs, >45yrs.	30-35yrs, 36-40yrs,

Do you have any post-registration qualifications?

Yes	No	N/A

If Yes, please specify

_____

_____

Do you have prior training as a preceptor?

Yes No

If Yes, please specify

_____

_____

B) PLEASE ANSWER THE FOLLOWING QUESTIONS

1. With whom have you previously worked as a preceptor? Please mark the appropriate box(es)

ECA	☐
Student Enrolled Nurse	☐
1st year student nurse	☐
2nd year student nurse	☐
3rd year student nurse	☐
Re-entry RN	☐
New RN	☐
New EN	☐
Other (please specify)	☐

_____

_____

2. Have you previously been preceptored by another nurse

Yes No

If yes please specify

_____

_____

3. Please list the attributes/qualities that you consider important in a good preceptor.

_____

_____

4. Please list the attributes/qualities that you consider important in a good preceptee/student.

_____

_____

5. What issues can you identify as:

a) facilitating your role as a preceptor

_____

_____

b) undermining your role as a preceptor

_____

_____

6. What concerns do you have with respect to your own ability to preceptor 2nd year nursing students who are on their first clinical placement?

_____

_____

7. Please write down three of more expectations for your own learning as a consequence of your participation in the research project.

c)

_____

_____

d)

_____

_____

e)

_____

_____

f)

_____

_____

8. Is there anything else that you want to add?

_____

_____

Appendix 4: Student Nurse Initial Evaluation – Part 2

RESIDENTIAL AGED CARE PRECEPTOR PROJECT

Student Nurse Initial Evaluation May 2004

Part Two

1. When you arrived in the aged care facility were made to feel comfortable and welcome

Very welcome welcome unwelcome very unwelcome

2. How did this make you feel?

_____

_____

_____

_____

3. When you arrived on the aged care ward did you preceptor know you were coming?

Yes No

4. How did this make you feel?

_____

_____

5. Following graduation would you consider working in aged care (Circle appropriate response)

Definitely possibly possibly not definitely not

Appendix 5: Orientation Checklist – Student

UNIVERSITY OF TASMANIA

Building Connections in Aged Care

Orientation Checklist – Student

May 2004

Facility: Karingal **M St V** **QVH** **Vaucluse** **LPHA** **Manor**

Please tick the appropriate response

On your orientation day to the facility were you:

	YES	NO
Did one person coordinate your orientation?	❒	❒
• Introduced to:		
○ the Director of Nursing	❒	❒
○ Other RNs	❒	❒
○ ENs	❒	❒
○ ECAs	❒	❒
○ Domestic & catering staff	❒	❒
• Shown you where to put your bag	❒	❒
• Shown where the toilets are	❒	❒

	YES	NO
• Shown the tea room	❒	❒
• Told how the shift would be organised – routines	❒	❒
• Told when and where you will have meal breaks	❒	❒
• Told what to do in the event of fire or emergency	❒	❒
• Shown where the fire exits are	❒	❒
• Told what to do when the phone rings	❒	❒
• Told what the smoking policy is	❒	❒
• Told where you can access computing	❒	❒
• Told what books/resources are available & where	❒	❒
• Told what times the shifts finish	❒	❒
• Told what time the shifts start	❒	❒
• Told what to do if you are running late or can't work that shift	❒	❒
• Told what to do if I feel sick on a shift & need to go home	❒	❒
• Told what to do if you need to go home early	❒	❒
• Told what to if you are feeling anxious or upset	❒	❒
• Told who to contact if hurt yourself	❒	❒
• Told where you can access a telephone to make a call	❒	❒
• Given an orientation to the unit/area (walk around)	❒	❒
• Given an overview of manual handling and lifting policy	❒	❒

Appendix 6: Student Nurse Final Evaluation May 2004

UNIVERSITY OF TASMANIA

RESIDENTIAL AGED CARE PRECEPTOR PROJECT

Student Nurse Final Evaluation May 2004

B) STUDENT INFORMATION

(Please circle appropriate response)

Region you are in practice? NW N S

Your Age? 18 -25yrs 26-30yrs 30-35yrs

36-39yrs 40-45yrs >45yrs

Have you previously worked in an aged care facility (i.e. as a carer etc)?

Yes No

If yes, in what capacity did you work

Therapy assistant EN ECA catering domestic staff

Other _____

Years working in aged care? < 6mths 6mths - 1yr 1- 5 yrs

6- 10 yrs >10yrs NA

Have you ever visited a relative in residential aged care facility?

Yes No

B) PLEASE ANSWER THE FOLLOWING QUESTIONS

1. **Was working in the residential care facility what you expected?**
(Circle appropriate response)

Yes No Don't Know

Please explain

_____

_____

2. Did you enjoy working with elderly residents?

Yes No Don't Know

3. Were you surprised by your response to working with elderly residents

Yes No Don't Know

Please explain

_____

_____

4. **How did meeting in the research group each week contribute to your clinical experience?**
(Circle appropriate response)

Extremely helpful very helpful somewhat helpful not at all helpful

Please explain

_____

_____

5. **How useful to your clinical placement was having access to the weekly case notes?**
(Circle appropriate response)

Extremely helpful very helpful somewhat helpful not at all helpful

Please explain

_____

_____

6. How useful was getting weekly feedback from the preceptors and being able to give them feedback?

Extremely helpful very helpful somewhat helpful. not at all helpful

Please explain

_____

_____

7. In this clinical placement did you find your nurse preceptors:

(Circle appropriate response)

(1) Very helpful helpful neutral unhelpful very unhelpful

(2) Very supportive supportive neutral unsupportive very unsupportive

(3) Very friendly friendly neutral unfriendly very unfriendly

How did this make you feel?

_____

_____

8. In this clinical placement did you find the ECAs you worked with:

(Circle appropriate response)

(1) Very helpful helpful neutral unhelpful very unhelpful

(2) Very supportive supportive neutral unsupportive very unsupportive

(3) Very friendly friendly neutral unfriendly very unfriendly

How did this make you feel?

_____

_____

9. **Following graduation would you consider working in aged care**
(Circle appropriate response)

Definitely possibly possibly not definitely not

10. Please rate how important each of the following statements is in deciding if you would work in aged care following graduation.

Rating scale

1. Very Important
2. Important
3. Uncertain
4. Unimportant
5. Very Unimportant

Please circle appropriate response below

a) Opportunities for autonomous practice	1	2	3	4	5
b) Being responsible for over 30 residents on a shift (work load)	1	2	3	4	5
c) Availability of flexible working hours	1	2	3	4	5
d) Ready availability of work	1	2	3	4	5
e) Ready availability of part time work	1	2	3	4	5
f) The opportunity to work with elderly people	1	2	3	4	5
g) The ability to provide continuity of care	1	2	3	4	5
h) The low professional status of aged care	1	2	3	4	5
i) The need for acute care experience first	1	2	3	4	5
j) The more administrative focus of the RN role in aged care	1	2	3	4	5
k) The ability to work with residents families over time	1	2	3	4	5
l) The lower salaries paid to RNs in aged care	1	2	3	4	5
m) Any other comments					

11. Please list the most enjoyable aspects of this experience?

_____

_____

12. Please list the least enjoyable aspects of this experience?

_____

_____

Appendix 7: Student Survey Stage 2 May 2004

UNIVERSITY OF TASMANIA

Tasmanian School of Nursing — Aged Care Preceptor Project

Student Survey

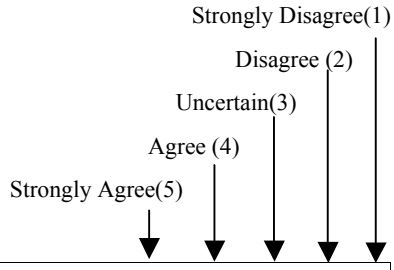
STAGE 2 MAY 04

CONFIDENTIAL

Please circle

Karingal Mt St Vs QVH Vaucluse LPHA Manor

Note: In this survey, the term preceptor refers to preceptors who are participating in the research project. The term student refers to student nurses undertaking clinical practice.



	Please circle one of the following indicators for each of these questions						
Q1	The preceptors were effective in welcoming me to the unit	Q1	5	4	3	2	1
Q2	My preceptors introduced me to fellow staff and patients	Q2	5	4	3	2	1
Q3	My preceptors facilitated my acceptance on the unit	Q3	5	4	3	2	1
Q4	My preceptors acknowledged my prior experience when structuring teaching and learning opportunities	Q4	5	4	3	2	1
Q5	My preceptors assisted me to make decisions about my learning objectives/needs	Q5	5	4	3	2	1
Q6	My preceptors helped me identify strategies to meet my learning objectives/needs	Q6	5	4	3	2	1
Q7	My preceptors encouraged me to be an active learner (eg to seek information from the library, negotiate learning opportunities)	Q7	5	4	3	2	1
Q8	I feel more confident about my nursing practice	Q8	5	4	3	2	1
Q9	My preceptors actively looked for opportunities to optimise my teaching and learning	Q9	5	4	3	2	1
Q10	Through working with my preceptor, he/ she gained useful information on the organization of the undergraduate curriculum	Q10	5	4	3	2	1
Q11	After this practice experience, I feel more confident about my competence in practice	Q11	5	4	3	2	1
Q12	When asked, my preceptor assessed my skills effectively	Q12	5	4	3	2	1
Q13	I received constructive feedback from my preceptors	Q13	5	4	3	2	1
Q14	I feel more positive about working with a preceptor than I did before	Q14	5	4	3	2	1

Appendix 8: RN/EN Final Evaluation June 2004

UNIVERSITY OF TASMANIA

RESIDENTIAL AGED CARE PRECEPTOR PROJECT

STAGE 2

RN/EN Final Evaluation June 2004

A) PARTICIPANT INFORMATION (PLEASE CIRCLE APPROPRIATE RESPONSE)

Is this your first time in the project Yes No

B) PLEASE ANSWER THE FOLLOWING QUESTIONS

1. **How did meeting in the group facilitate your work as a preceptor?**

   Extremely helpful very helpful somewhat helpful not at all helpful

   Please explain

   _____

   _____

2. **How significant was having access to the weekly case notes to developing your role as a preceptor?**

   Extremely helpful very helpful somewhat helpful not at all helpful

Please explain

_____

_____

3. How significant was getting weekly feedback from the students and being able to give them feedback?

Extremely helpful very helpful somewhat helpful. not at all helpful

Please explain

_____

_____

4. As a consequence of your participation in the research project, has your knowledge of being a preceptor improved

Definitely possibly possibly not definitely not

Please explain

_____

_____

5. As a consequence of your participation in the research project, has your confidence in being a preceptor improved

Definitely possibly possibly not definitely not

Please explain

_____

_____

6. To what degree has working as a preceptor with students caused you to reflect on you practice?

Definitely possibly possibly not definitely not

Please explain

_____

_____

7. To what extent has working as a preceptor with students caused you to become a more active learner?

Definitely possibly possibly not definitely not

Please explain

_____

_____

8. Was working as a preceptor with students what you expected?

Yes No Don't Know

Please explain

_____

_____

9. Please list the most enjoyable aspects of your experience as a preceptor?

_____

_____

10. Please list the least enjoyable aspects of your experience as a preceptor?

_____

_____

11. In you estimation to what degree do you think having students in aged care facility has been of benefit to the residents?

Never Sometimes Often Always

Please explain

_____

_____

Appendix 9: Preceptor Survey Stage 2 May 2004

UNIVERSITY OF TASMANIA

Tasmanian School of Nursing — Aged Care Preceptor Project

Preceptor Survey

STAGE 2 May 04

CONFIDENTIAL

Please circle

Karingal Mt St Vs QVH Vaucluse LPHA Manor

NOTE: In this survey, the term preceptor refers to preceptors who are participating in the research project. The term student refers to nursing students undertaking clinical practice

Strongly Disagree(1)
Disagree (2)
Uncertain (3)
Agree (4)
Strongly Agree(5)

Please circle ONE of the following indicators for each of these questions.

Q1	As a preceptor, I feel confident in welcoming students into the unit	Q1	5	4	3	2	1
Q2	As a preceptor, I am effective in introducing students to fellow staff and patients	Q2	5	4	3	2	1
Q3	I facilitated the student's acceptance on the unit	Q3	5	4	3	2	1
Q4	I am able to acknowledge the student's prior experience to more effectively structure teaching and learning opportunities	Q4	5	4	3	2	1
Q5	I am able to assist the student to make decisions about learning objectives/needs	Q5	5	4	3	2	1
Q6	I can facilitate the students in finding strategies to meet learning objectives/needs	Q6	5	4	3	2	1
Q7	I have the ability to encourage students to be active learners (eg to seek information from the library, negotiate learning opportunities)	Q7	5	4	3	2	1
Q8	I have the ability to support students to develop their competence in practice	Q8	5	4	3	2	1
Q9	I actively look for opportunities to optimise the teaching and learning of students	Q9	5	4	3	2	1
Q10	Working with students supported the development of my knowledge of the undergraduate curriculum	Q10	5	4	3	2	1
Q11	After this experience, I think the students feel more confident in practice	Q11	5	4	3	2	1
Q12	When asked, I felt confident assessing the students skills	Q12	5	4	3	2	1
Q13	I am able to provide constructive feedback to the students	Q13	5	4	3	2	1
Q14	Working with students has made me feel much more positive about being a preceptor than I did before	Q14	5	4	3	2	1
Q15	Having the opportunity to work as a preceptor made me feel more valued as a Registered Nurse/ Enrolled Nurse	Q15	5	4	3	2	1

Appendix 10: Supervision and Placement Activities Log

Building Connections in Aged Care

Stage Two

Student Instructions for Completing the Supervision and Placement Activities Log

As part of your involvement in this study we would like you to complete this supervisor and placement log as completely as possible. This data will be used to further develop teaching and learning strategies within residential aged care facilities.

For each hour of each day you need to record whom you worked with/ were supervised by and the activities you undertook. Below are two tables providing you with codes to insert into the relevant cells on the log tables. If you were working alone (which will happen), please use the code for working alone or unsupervised.

Record only the predominant supervisor/activity or procedure that you undertook during each hour block i.e. more than 60% of that hour i.e. over half an hour.

Person	Example	Code
Registered nurse D*	Greater than 60% of your time was spent directly working with a RN eg you are participating in the same activity eg you are handing out medications together	101
Registered nurse I*	Less than 60% of your time was spent directly working with a RN i.e. you are not participating in the same activity as the RN, but they are providing you with guidance eg you are showering a resident and the RN is completing a care plan	102
Enrolled nurse D*	Greater than 60% of your time was spent directly working with an EN i.e. you are participating in the same activity eg you are undertaking wound management activities together	103
Enrolled nurse I*	Less than 60% of your time was spent directly working with an EN i.e. you are not participating in the same activity as the EN, but they are providing you with guidance eg you are showering a resident and the EN is making the bed	104
ECA or PCA D*	Greater than 60% of your time was spent directly working with an ECA/PCA eg you are participating in the same activity eg you are handing undertaking manual handling activities	105
ECA or PCA I*	Less than 60% of your time was spent directly working with an ECA/PCA ie you are not participating in the same activity as the ECA/PCA, but they are providing you with guidance eg you are assisting a resident with their meal and the ECA/PAC is feeding another resident	106
Other Health Workers	Working with a physiotherapist, diversional therapist, general practitioner	107
Working alone	Greater than 60% of your hour was spent working without any supervision/guidance eg sitting and doing uni work, preceptor on a break	108
Absent	Did not attend clinical practice	109
Sick leave	Unable to attend clinical practice due to illness/injury (certificate provided)	110

*** D represents direct supervision I represents indirect supervision**

Activity or procedure	Example	Code
Handover	Attending or giving information relating to resident to other staff	201
Hygiene	Shower, bath, sponge, toileting, Dermalux, making beds, preparing clothes	202
Activities of daily living	Ambulation, manual handling, range of movement exercises, assisting resident with meals	203
Diversional therapy	Craft, TV, talking with resident	204
Medication management	Observing, participating, planning delivery of medications (oral, rectal, IV, IMI, SC injections, peg, syringe driver, transdermal)	205
Wound management	Observation or participation in undertaking wound assessment and management (debridement, swabbing, bandaging)	206
Observations	Temp, BP, Pulse, resps, BSL, pulse oxymetry	207
Documentation	Care plans, RCS documents, resident notes, OBS charts	208
University activities	Assignments (including interviewing resident), Bioscience revision	209
Other nursing procedures	Taking bloods, inserting catheter, catheter toilet, nasogastric feeds, oxygen therapy, resident transport	210
Non nursing activities	Mopping floors, stock take, tidying shelves	211
Doing nothing	Waiting for supervision (can't find RN), not knowing what to do, no suitable activities/procedures available	212
Orientation	Activities related to becoming familiar with the facility, policies, protocols,	213
Other activities	Please specify	214

Example of completed log:

Table one – what you actually did

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800	RN direct	Injections	RN direct	Drug round	RN direct	Attended handover		Away all day sick	EN direct med endorsed	Drug round
0800-0900	ECA indirect	showers	EN direct	Changing a dressing	EN direct	Waiting for EN to supervise a dressing			RN direct	Taking bloods

Table two – what we want recorded

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800	101	205	101	205	101	201	110		103	205
0800-0900	106	202	103	206	103	212	110		101	210

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Week 1	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800										
0800-0900										
0900-1000										
1000-1100										
1100-1200										
1200-1300										
1300-1400										
1400-1500										
1500-1600										
1600-1700										
1700-1800										
1800-1900										
1900-2000										
2000-2100										
2100-2200										
2200-2300										

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Week 2	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800										
0800-0900										
0900-1000										
1000-1100										
1100-1200										
1200-1300										
1300-1400										
1400-1500										
1500-1600										
1600-1700										
1700-1800										
1800-1900										
1900-2000										
2000-2100										
2100-2200										
2200-2300										

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Week 3	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800										
0800-0900										
0900-1000										
1000-1100										
1100-1200										
1200-1300										
1300-1400										
1400-1500										
1500-1600										
1600-1700										
1700-1800										
1800-1900										
1900-2000										
2000-2100										
2100-2200										
2200-2300										

Example of completed log:

Table one – what you actually did

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800	RN direct	Injections	RN direct	Drug round	RN direct	Attended handover		Away all day sick	EN direct med endorsed	Drug round
0800-0900	ECA indirect	showers	EN direct	Changing a dressing	EN direct	Waiting for EN to supervise a dressing			RN direct	Taking bloods

Table two – what we want recorded

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800	101	205	101	205	101	201	110		103	205
0800-0900	106	202	103	206	103	212	110		101	210

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Week 1	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800										
0800-0900										
0900-1000										
1000-1100										
1100-1200										
1200-1300										
1300-1400										
1400-1500										
1500-1600										
1600-1700										
1700-1800										
1800-1900										
1900-2000										
2000-2100										
2100-2200										
2200-2300										

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Week 2	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800										
0800-0900										
0900-1000										
1000-1100										
1100-1200										
1200-1300										
1300-1400										
1400-1500										
1500-1600										
1600-1700										
1700-1800										
1800-1900										
1900-2000										
2000-2100										
2100-2200										
2200-2300										

Time	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Week 3	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure	Supervisor	Activity or procedure
0700-0800										
0800-0900										
0900-1000										
1000-1100										
1100-1200										
1200-1300										
1300-1400										
1400-1500										
1500-1600										
1600-1700										
1700-1800										
1800-1900										
1900-2000										
2000-2100										
2100-2200										
2200-2300										

Appendix 11: Letter

UNIVERSITY OF TASMANIA

6th April 2004

Dear

Thank you for your continued support towards student learning by agreeing to provide placements for second year nursing students in 2004 as a part of the unit *Supportive Care in Hospital and Community Settings 1*.

Supportive Care in Hospital and Community Settings 1 builds on studies undertaken in year one and is designed to develop a substantive framework of knowledge and skills. Students are currently exploring health issues associated with episodic and chronic illness while integrating a critical thinking approach. The students will be on placement for three weeks, Monday to Friday, and they are available for eight-hour shifts (morning and afternoon). The semester 1 placement commences on 10th May 2004 and concludes on 28th May 2004. The student names for this placement are attached to this letter.

Please find enclosed a copy of the study schedule, which outlines the content covered this semester, a condensed summary of the assessment tasks to be completed by each student while in practice and a *Clinical Placement Workbook, which* has been developed for the students. This workbook contains: a record of attendance; practice aims; a proposed weekly guide, and assessment items. Each student will be required to: submit nine 'Episodes of Practice'; demonstrate a satisfactory performance using identified cues (ANC National Nursing Competency Standards for the Registered Nurse), and demonstrate a developing sense of professional responsibility ('Towards Competence' sheet - a non assessable/compulsory item).

During the three-week placement a bat mobile phone (0408121352) will also be in use to answer any queries that may arise. In the meantime if you have any questions or comments please do not hesitate to call or email me.

Kind regards

Heidi Mc Dermott

Supportive Care in Hospital and Community Settings 1 Coordinator

Appendix 12: Analysis of Supervision and Placement Activities Log

Aims

- **To identify what activities were undertaken by student nurses during clinical placement in residential aged care settings; and**
- **To identify the level of supervision of students during clinical practice.**

Background

Staff from the SNM collaborated with six residential aged care facilities in a Commonwealth funded project, 'Building Connections in Aged Care – Developing support structures for student nurses on placement in residential care'. Previous work highlighted that student nurses held negative perceptions towards working in aged care, however it has since been shown that if students are exposed to aged care experiences in a supported environment, more than 90% would consider working in aged care after graduation. To gain further understanding of the experiences of the students in clinical practice, it was necessary to know what activities and procedures they were undertaking and who was supervising them.

During Stage 1 of the 'Building Connections' project the 'Supervision and Placement Activities Log' (known as the 'log') was trialled for the students to record their level of supervision and activities undertaken. This tool was further developed and implemented in Stage two. Students used a key to complete a grid for each hour, of each day, of the three weeks in clinical practice detailing who was supervising each activity undertaken. A coding system provided students with a list and examples of potential activities and procedures as well as supervisors. Provision was made for adding additional information.

From initial analysis it appears that students spend a disproportionate amount of their time (approximately 40%) supervised by other health workers including ENs and PCAs undertaking 'basic care'. If students are to be competent novice practitioners at registration, they need to be exposed to the role of the RN.

Definitions

The Nursing Board of Tasmania defines direct and indirect supervision:

- Supervision involves the participant being directly or indirectly supervised by a registered nurse, or authorised midwife.
- Direct supervision refers to delegated responsibilities being undertaken by the participant under direct observation of the preceptor in the interests of safe and/or competent practice.
- Indirect supervision is where, in the professional judgement of the preceptor, direct supervision is not required in the interests of safe/or competent practice (Nursing Board of Tasmania 2003).

Method

The 'Supervisor Log' used in Stage 1 was reviewed and modified to:

- Simplify the research tool;
- Increase student compliance in completing the 'log';
- Increase the accuracy and;
- Increase the quality of the data collected; and
- Reduce data entry time.

Prior to the commencement of the practicum each participating student was provided with a copy of the 'log' (Appendix 11). The project manager facilitated student learning, on the requirements for completion of the 'log'. A case study approach was used to demonstrate the method. An example of a partially completed 'log' was included with the 'log' for future reference. Students were requested to indicate the category of worker they were assigned to, and to indicate the nature of tasks, activities and procedures they undertook for the majority of each hour. This was undertaken for each hour of each day during the practicum. Each cell represented one hour. Working alone or unsupervised work, sick leave and absenteeism information was also elicited. A coding key was provided to the students as part of the 'log'. This key was developed to facilitate ease of data entry and reduce the potential for coding errors.

Students were provided with a copy of the 'log' at the completion of the induction session. They were encouraged to complete the 'log' after each shift of clinical practice, or where time permitted, during the shift. The 'logs' were collected from the majority of students during the last research meeting. Remaining 'logs' were posted to the project manager or collected by the research assistants. Data was not collected for the last day of the practicum because it did not reflect a normal nursing day. Some students use the last day to travel from the facility to their usual place of residence, others attend farewell functions during the day.

Data analysis was undertaken using SPSS™ version 11.5. New variables were coded during data entry to reflect attendance at research meetings with university staff, meal breaks, absenteeism and sick leave.

Results

Twenty one students consented to be included and were allocated placement at the facilities under study. However, due to unforeseen circumstances only twenty students completed the 'log'. Data were analysed for 14 days of the practicum. For the purpose of systematic data entry it was assumed that morning shifts were between 0700 and 1500 hours. Afternoon shifts were assumed to be between 1400-2200 hours. Missing data was recorded for any blank cells found in the 'log'.

Key findings from analyses of the 'log' were:

2. A wide range of clinical activities were undertaken by the students (n=12) (Table 15 and Figure 39);
3. The number of student hours spent on each of the different activities and procedures varied across the six facilities (Table 15 and Figure 39).
4. A large proportion of the students' time involved medication management (22.7%), hygiene activities (13.1%) and activities of daily living (11.4%). (Table 16).

5. Student nurses were directly supervised by RNs 34.9% of the time, and indirectly supervised by RNs 4.7% of the time. A total of 39.6% of student activities and procedures were being supervised by RNs (Table 17).
6. Students were supervised by ENs a total of 19.9% of the time; and
7. Students were supervised by PCAs a total of 14.6% of the time (Table 17).
8. While working under the direct supervision of RNs, students mainly undertook medication management activities (49.1% of this time), wound management (13.3% of this time) and orientation on the first day (11.2% of this time) (Table 19).
9. While working directly with ENs, students spent 32.3% of their time involved in medication management (Table 19). Data collected using the 'log' does not discriminate between observation, planning or dispensing of medication by students. However, if students were dispensing medication under supervision of a medication endorsed EN or EN this is of concern. Medication endorsed ENs or ENs are not permitted to supervise students administering medications.
10. In week 1, 25% of activities involving medication management activities undertaken by students were with other than RNs. Students reported in the 'log' they were undertaking, planning, observing or dispensing of medications under direct or indirect supervision of an EN or PCA. During week 2, incorrect supervision was 22% and during week 3 it was reported at 23%. The practice continued predominantly at one facility.
11. Direct supervision of students by RNs decreased from 40.3% during week 1, to 27.4% in Week 3. Orientation activities are generally conducted during the initial shifts and could partly attribute to the decrease in reported supervision. Additionally, student confidence and competence could have increased during the practicum and through the clinical decision making process, RNs chose to give the students 'more space' to undertake activities and procedures. The indirect supervision of students by RNs increased during the practicum from 3.8% in week 1, to 5.7% in Week 3 (Table 23, Table 24 and Table 25).
12. Students reported time spent alone increased from 10.4% during week 1 to 16.7% during week 3. An increase in student confidence and competency, plus a development of an understanding of the routine, policies and protocols of the facilities they were nursing at could be partly attributed to this increase.
13. Overall, the proportion of time students spent undertaking various activities during clinical practice did not alter significantly. Excluding orientation, student time spent undertaking university activities increased from 4.2% during week 1, to 12.1% during week 3. Similarly, wound management activities increased from 5.0% in week to 8.1% in week 3. Conversely, medication management, documentation, hygiene and activities of daily living reduced marginally during the three week period (Table 26, Table 27 and Table 28).
14. Students reported that they did not spend any time 'doing nothing' in week 3. This lack of report could indicate that students by week 3 had gained an insight into the routine of the facility where they were working and were resourceful enough to undertake activities or procedures they did not realise occurred when they first started their clinical practice (Table 26, Table 27 and Table 28).

Other findings included:

1. Across the three week period, students were sick for 2.3% of the practicum and absent for 1.2% of their allocated time in practice (Table 16).
2. Sick leave was highest at RACF 2 (16 hours) and three facilities recorded absenteeism of 8 hours (Table 15).

3. Students worked with physiotherapists, community nurses, diversional and occupational therapists, or attended in-service sessions for 4.7% of their time (Table 17).
4. Students attended research meetings with university staff for 4.1% of the practicum.
5. On the whole, the three students who were placed at RACF 4 spent more hours with RNs during the fourteen days (246 hours). The four students at the RACF 5 Home spent the least number of hours working with RNs (13 hours) (Table 18).
6. Students spent the most number of hours working with PCAs at the RACF 5 (Table 18). This facility has the highest number of PCAs and the highest number of residents of the six facilities involved in the project.
7. Students at RACF 4 reported the highest number of hours working with University staff during the research meetings (Table 18). This could be attributed to the amount of time they spent travelling between facilities for the meetings.
8. While indirectly supervised by RNs, the students completed documentation (19.4%); university activities including the 'log' and 'episodes of practice'; (16.1%); hygiene (11.8%) and medication management (10.8%) (Table 19).
9. Direct supervision of students by ENs remained consistent during the three week period (Table 23, Table 24 and Table 25).
10. Supervision by PCAs decreased during the period of clinical practice (Table 22, Table 23 and Table 24).

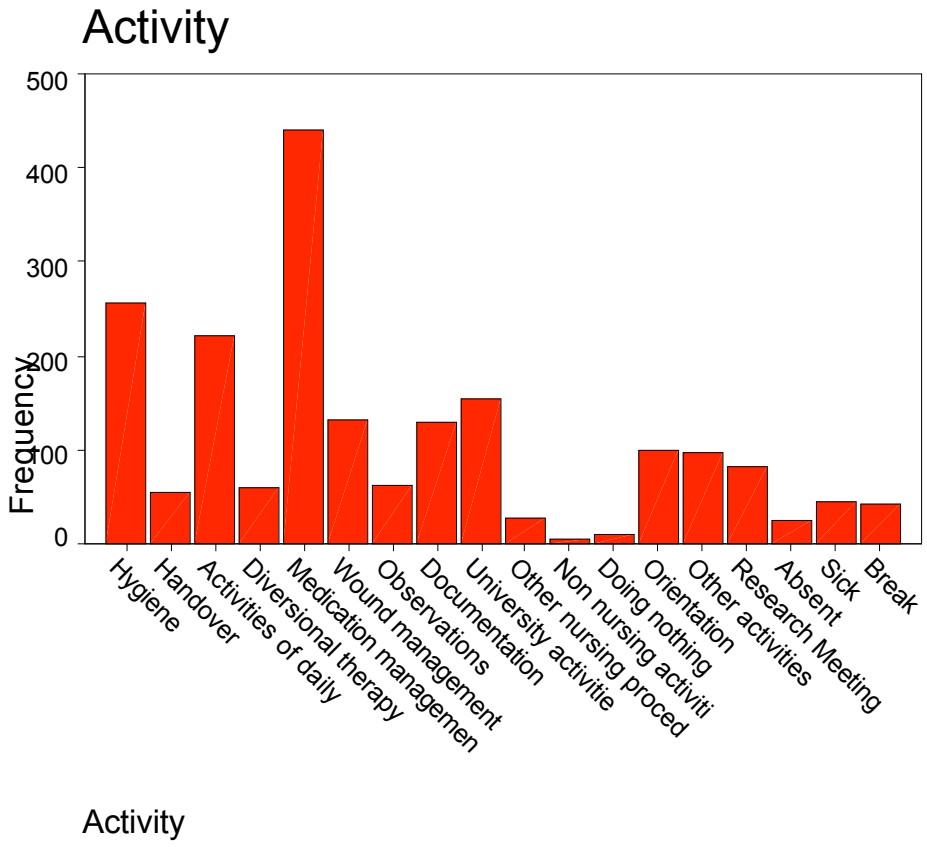


Figure 39: Bar chart showing frequency of each activity

Table 17: Percentage of total student hours supervised by health care worker

	Supervisor	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Registered Nurse D	691	32.6	34.9	34.9
	Registered Nurse I	93	4.4	4.7	39.6
	Enrolled Nurse D	230	10.8	11.6	51.2
	Enrolled Nurse I	165	7.8	8.3	59.6
	ECA or PCA D	143	6.7	7.2	66.8
	ECA or PCA I	147	6.9	7.4	74.2
	Other health workers	93	4.4	4.7	78.9
	Working alone	244	11.5	12.3	91.3
	Absent	32	1.5	1.6	92.9
	Sick leave	60	2.8	3.0	95.9
	University Staff	81	3.8	4.1	100.0
	Total	1979	93.3	100.0	
Missing	missing	142	6.7		
Total		2121	100.0		

Table 18: Supervision of activities (hours) across each of the six RACFs

Count

		Facility						Total
		RACF3	RACF2	RACF4	RACF1	RACF5	RACF6	
Supervisor	Registered Nurse D	108	109	211	190	13	60	691
	Registered Nurse I	6	5	35	24	0	23	93
	Enrolled Nurse D	41	29	29	0	61	70	230
	Enrolled Nurse I	7	4	15	0	108	31	165
	ECA or PCA D	51	13	18	15	34	12	143
	ECA or PCA I	12	20	17	3	76	19	147
	Other health workers	0	9	31	2	29	22	93
	Working alone	48	17	47	49	40	42	243
	Absent	8	8	0	0	8	8	32
	Sick leave	23	16	5	8	0	8	60
	University Staff	16	13	20	13	10	10	82
Total		320	243	428	304	379	305	1979

Figure 40: Supervision hours across each of the six RACFs

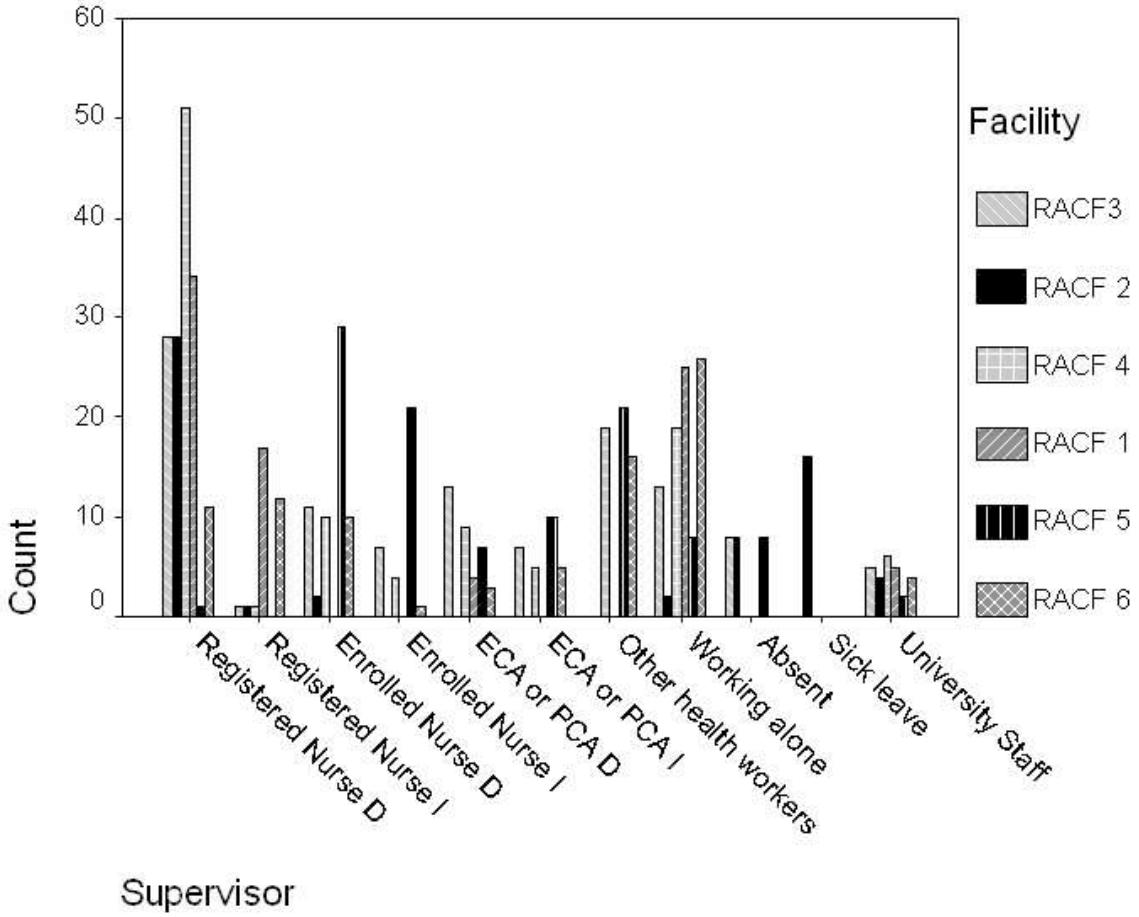


Table 19: Activities undertaken by direct supervision by a registered nurse

Activity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hygiene	3	.4	.4	.4
	Handover	38	5.5	5.5	6.0
	Activities of daily living	13	1.9	1.9	7.9
	Diversional therapy	2	.3	.3	8.2
	Medication management	337	48.8	49.1	57.3
	Wound management	91	13.2	13.3	70.6
	Observations	18	2.6	2.6	73.2
	Documentation	48	6.9	7.0	80.2
	University activities	15	2.2	2.2	82.4
	Other nursing procedures	18	2.6	2.6	85.0
	Non nursing activities	2	.3	.3	85.3
	Orientation	77	11.1	11.2	96.5
	Other activities	22	3.2	3.2	99.7
	Break	2	.3	.3	100.0
	Total	686	99.3	100.0	
Missing	missing	5	.7		
Total		691	100.0		

Table 20: Supervision of medication management activities - Week 1

Count

		Facility						
		RACF 3	RACF 2	RACF 4	RACF 1	RACF 5	RACF 6	Total
Supervisor	Registered Nurse D	19	22	31	40	0	13	125
	Registered Nurse I	1	0	1	0	0	1	3
	Enrolled Nurse D	6	6	5	0	9	5	31
	Enrolled Nurse I	0	0	0	0	5	0	5
	ECA or PCA D	0	0	0	0	2	0	2
	Working alone	0	0	0	0	1	0	1
Total		26	28	37	40	17	19	167

Table 21: Supervision of medication management activities - Week 2

Count

		Facility						
		RACF 3	RACF 2	RACF 4	RACF 1	RACF 5	RACF 6	Total
Supervisor	Registered Nurse D	19	19	45	29	1	15	128
	Registered Nurse I	1	0	1	0	0	0	2
	Enrolled Nurse D	7	6	0	0	13	2	28
	Enrolled Nurse I	0	0	0	0	5	0	5
	ECA or PCA D	2	0	0	0	0	0	2
Total		29	25	46	29	19	17	165

Table 22: Supervision of medication management activities - Week 3

Count

		Facility						
		RACF 3	RACF 2	RACF 4	RACF 1	RACF 5	RACF 6	Total
Supervisor	Registered Nurse D	17	19	26	18	0	4	84
	Registered Nurse I	0	0	0	5	0	0	5
	Enrolled Nurse D	3	0	0	0	12	0	15
	Enrolled Nurse I	1	0	0	0	1	0	2
	ECA or PCA D	0	0	0	0	3	0	3
Total		21	19	26	23	16	4	109

Tables and Figures

Table 15: Raw number of hours of each activity undertaken by students in each of the six RACFs

Count

		Facility						Total
		RACF3	RACF2	RACF4	RACF1	RACF5	RACF6	
Activity	Hygiene	44	17	58	6	78	52	255
	Handover	15	10	9	15	3	3	55
	Activities of daily living	31	14	20	7	103	46	221
	Diversional therapy	1	3	11	4	23	18	60
	Medication management	76	72	109	92	52	40	441
	Wound management	21	15	36	35	12	14	133
	Observations	8	10	12	2	13	18	63
	Documentation	13	22	33	15	32	14	129
	University activities	37	7	31	51	16	12	154
	Other nursing procedures	1	1	11	6	4	4	27
	Non nursing activities	0	0	2	1	0	3	6
	Doing nothing	3	0	0	0	5	1	9
	Orientation	18	17	15	20	16	13	99
	Other activities	3	7	45	15	5	22	97
	Research Meeting	15	13	20	13	10	10	81
	Absent	0	8	0	0	8	8	24
	Sick	8	16	5	8	0	8	45
	Break	2	7	5	13	1	15	43
Total		296	239	422	303	381	301	1942

Table 16: Percentage of total student hours worked undertaking each of the listed activities

Activity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hygiene	255	12.0	13.1	13.1
	Handover	55	2.6	2.8	16.0
	Activities of daily living	221	10.4	11.4	27.3
	Diversional therapy	60	2.8	3.1	30.4
	Medication management	441	20.8	22.7	53.1
	Wound management	133	6.3	6.8	60.0
	Observations	63	3.0	3.2	63.2
	Documentation	129	6.1	6.6	69.9
	University activities	154	7.3	7.9	77.8
	Other nursing procedures	27	1.3	1.4	79.2
	Non nursing activities	6	.3	.3	79.5
	Doing nothing	9	.4	.5	80.0
	Orientation	99	4.7	5.1	85.1
	Other activities	97	4.6	5.0	90.1
	Research Meeting	81	3.8	4.2	94.2
	Absent	24	1.1	1.2	95.5
	Sick	45	2.1	2.3	97.8
	Break	43	2.0	2.2	100.0
	Total	1942	91.6	100.0	
Missing	missing	179	8.4		
Total		2121	100.0		

Table 23: Supervision of activities undertaken in Week 1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Registered Nurse D	287	36.6	40.3	40.3
	Registered Nurse I	27	3.4	3.8	44.1
	Enrolled Nurse D	82	10.4	11.5	55.6
	Enrolled Nurse I	49	6.2	6.9	62.5
	ECA or PCA D	75	9.6	10.5	73.0
	ECA or PCA I	56	7.1	7.9	80.9
	Other health workers	20	2.5	2.8	83.7
	Working alone	74	9.4	10.4	94.1
	Absent	8	1.0	1.1	95.2
	Sick leave	5	.6	.7	95.9
	University Staff	29	3.7	4.1	100.0
	Total	712	90.7	100.0	
Missing	missing	73	9.3		
Total		785	100.0		

Table 24: Supervision of activities undertaken in Week 2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Registered Nurse D	251	33.9	35.4	35.4
	Registered Nurse I	34	4.6	4.8	40.2
	Enrolled Nurse D	86	11.6	12.1	52.3
	Enrolled Nurse I	83	11.2	11.7	64.0
	ECA or PCA D	32	4.3	4.5	68.5
	ECA or PCA I	64	8.6	9.0	77.6
	Other health workers	17	2.3	2.4	80.0
	Working alone	76	10.3	10.7	90.7
	Sick leave	39	5.3	5.5	96.2
	University Staff	27	3.6	3.8	100.0
	Total	709	95.8	100.0	
Missing	missing	31	4.2		
Total		740	100.0		

Table 25: Supervision of activities undertaken in Week 3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Registered Nurse D	153	25.7	27.4	27.4
	Registered Nurse I	32	5.4	5.7	33.2
	Enrolled Nurse D	62	10.4	11.1	44.3
	Enrolled Nurse I	33	5.5	5.9	50.2
	ECA or PCA D	36	6.0	6.5	56.6
	ECA or PCA I	27	4.5	4.8	61.5
	Other health workers	56	9.4	10.0	71.5
	Working alone	93	15.6	16.7	88.2
	Absent	24	4.0	4.3	92.5
	Sick leave	16	2.7	2.9	95.3
	University Staff	26	4.4	4.7	100.0
	Total	558	93.6	100.0	
Missing	missing	38	6.4		
Total		596	100.0		

Table 26: Activities undertaken across each of the six facilities in Week 1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hygiene	102	13.0	14.3	14.3
	Handover	19	2.4	2.7	17.0
	Activities of daily living	88	11.2	12.3	29.3
	Diversional therapy	11	1.4	1.5	30.9
	Medication management	167	21.3	23.4	54.3
	Wound management	36	4.6	5.0	59.3
	Observations	15	1.9	2.1	61.4
	Documentation	58	7.4	8.1	69.6
	University activities	30	3.8	4.2	73.8
	Other nursing procedures	7	.9	1.0	74.8
	Non nursing activities	4	.5	.6	75.3
	Doing nothing	3	.4	.4	75.7
	Orientation	89	11.3	12.5	88.2
	Other activities	27	3.4	3.8	92.0
	Research Meeting	29	3.7	4.1	96.1
	Absent	8	1.0	1.1	97.2
	Sick	5	.6	.7	97.9
	Break	15	1.9	2.1	100.0
	Total	713	90.8	100.0	
Missing	missing	72	9.2		
Total		785	100.0		

Table 27: Activities undertaken across each of the six facilities in Week 2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hygiene	90	12.2	13.1	13.1
	Handover	26	3.5	3.8	16.9
	Activities of daily living	76	10.3	11.1	28.0
	Diversional therapy	16	2.2	2.3	30.4
	Medication management	165	22.3	24.1	54.5
	Wound management	53	7.2	7.7	62.2
	Observations	36	4.9	5.3	67.4
	Documentation	42	5.7	6.1	73.6
	University activities	58	7.8	8.5	82.0
	Other nursing procedures	11	1.5	1.6	83.6
	Non nursing activities	1	.1	.1	83.8
	Doing nothing	6	.8	.9	84.7
	Orientation	7	.9	1.0	85.7
	Other activities	34	4.6	5.0	90.7
	Research Meeting	26	3.5	3.8	94.5
	Sick	24	3.2	3.5	98.0
	Break	14	1.9	2.0	100.0
	Total	685	92.6	100.0	
Missing	missing	55	7.4		
Total		740	100.0		

Table 28: Activities undertaken across each of the six facilities in Week 3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hygiene	63	10.6	11.6	11.6
	Handover	10	1.7	1.8	13.4
	Activities of daily living	57	9.6	10.5	23.9
	Diversional therapy	33	5.5	6.1	30.0
	Medication management	109	18.3	20.0	50.0
	Wound management	44	7.4	8.1	58.1
	Observations	12	2.0	2.2	60.3
	Documentation	29	4.9	5.3	65.6
	University activities	66	11.1	12.1	77.8
	Other nursing procedures	9	1.5	1.7	79.4
	Non nursing activities	1	.2	.2	79.6
	Orientation	3	.5	.6	80.1
	Other activities	36	6.0	6.6	86.8
	Research Meeting	26	4.4	4.8	91.5
	Absent	16	2.7	2.9	94.5
	Sick	16	2.7	2.9	97.4
	Break	14	2.3	2.6	100.0
	Total	544	91.3	100.0	
Missing	missing	52	8.7		
Total		596	100.0		

Variables

Table 29 outlines the variables used in analysing the data with SPSS.

Table 29: Variables used in analysis

Variable	Description	Code
Student	**Numeric identifier**	**1-20**
Facility	**Missing, RACF1-RACF6**	**0-6**
Week	**Missing, Week 1, Week 2, Week 3**	**0-3**
Day	**Missing, Monday, Tuesday, Wednesday, Thursday, Friday**	**0-5**
Time	**Assuming an 8 hour shift less breaks**	**0700-1500 or 1400-2200**
Activity	**See code included in log**	**201-218**
Supervisor	**See code included in log**	**101-1**

Discussion

The limitations identified in Stage 1 were significantly reduced by coding the data during the collection process. This process reduced any ambiguity of activity or supervisor entered by students for each of the cells. Additionally, the amount of extraneous information supplied by students was reduced. The completion rate and return of the 'logs' (n=20) was higher than in Stage 1 and the use of the modified 'log' appeared to be successful because there were significantly less incomplete cells recorded. These were recorded as 'missing' during the data entry process.

The project manager who undertook the induction session received verbal concerns about completion of the 'log' from students. These included the perception that log completion would be time consuming, and would impinge on their practice and study commitments. Additionally, some students perceived that the coding system appeared confusing. The high completion and return rate together with anecdotal evidence suggests that the system was simple and easy to complete and was incorporated into student clinical practice time. Students also reported that completion of the 'log' was quicker than anticipated and did not impinge on other activities. Some students reported that they rapidly learnt the codes, which further reduced the amount of time spent completing the 'log'. Although the use of a coding key reduced data coding time for preparation for analyses, data entry was time consuming. Each student 'log' required 40 to 60 minutes per each to input into SPSS™ prior to data cleaning and manipulation.

The students when completing the 'log' encountered few difficulties. They did however suggest they would have liked the cells divided into half hour units of time, as many activities did not last more that the 60% of the hour required in the instructions. This suggestion will not be considered for implementation in the future because it would double the amount of

data obtained may not enhance the quality or the specificity of the data collected. Furthermore, the doubling of the quantity of data collected would be problematic, due to time constraints in entering and analysing the data and reporting the results.

It is affirming to report that RN time was utilised undertaking medication management, wound management and documentation. Undertaking these activities with an RN is an appropriate use of student time and RN resources.

According to NBT guidelines, students can only undertake medication management when an RN directly supervised them. During the period of research, the 'logs' highlighted that some facilities were allowing students to observe, plan or dispense medications without supervision of an RN. This anomaly was discussed at a research meeting during week 1, and some facilities rectified the practice. Although student numbers reporting in the 'logs' was low, it is of concern that analyses of medication management activities recorded by students in the 'log' showed that students were participating in this activity with direct or indirect supervision of an EN. The issue was addressed and the practice ceased at four of the facilities and reduced in one facility.

Conversely, hygiene and ADL activities were undertaken with indirect or direct supervision of a PCA. It is also affirming that students were under guidance when conducting these activities. Furthermore, students documented that when they were working alone it was generally spent undertaking university practice workbook activities. It was affirming and appropriate that students were undertaking this activity by themselves.

The lack of change over time in activities undertaken is not surprising. However, students reported time spent alone increased during the period under study. Student confidence and competency, plus a development of an understanding of the routine, policies and protocols of the facilities they were nursing at could be partly attributed to this increase. Similarly, students reported that they did not spend any time 'doing nothing' in week 3. This lack of report could indicate that students by week 3 they had gained an insight into the routine of the facility where they were working and were resourceful enough to undertake activities or procedures they did not realise occurred when they first started their clinical practice.

Conclusion

The completion of 'logs' by students has provided significant information about activities and procedures undertaken and levels of supervision of nursing students. Although this information cannot be extrapolated to other residential aged care facilities, it has provided useful information about the quality and quantity of activities and procedures and support provided to students involved with this project. Additionally, it provides facilities with a 'snapshot' of their clinical teaching and preceptor practice. This process is a useful quality assurance practice that could be incorporated into 'usual working practice' when students are present within these facilities. These results also provide an opportunity for facilities to benchmark themselves with other facilities that undertake student teaching and learning activities.

Revision and implementation of the Stage 1 tool in Stage 2 has effectively elicited supporting documentation about the type of activities and level of supervision of undergraduate student nurses during clinical practice at six residential aged care facilities. This information is vital in assessing the quality of student clinical placements.

Recommendations

- Further refinement of the research tool, to identify and differentiate between correct and incorrectly supervised activities; provide feedback to facilities about the level of supervision of students undertaking these activities; and provision of continuity of care.
- Facilitate an understanding of the need for students to be further exposed to the role and function of an RN during clinical practice. This includes the organisational and administrative processes required to provide holistic client care;
- Students could keep 'logs' for quality assurance purposes, as part of the quality assurance of teaching/learning of students and facilities;
- 'Logs' could be utilised as part of the benchmarking process for facilities that could assist with accreditation of facilities that are 'gold standard'; and
- Each student could be expected to spend a minimum proportion of time with an RN, and a proportion of student time could be spent undertaking certain activities with supervision of an RN that is worth a proportion of their academic grade.

References

AIHW (2003a). Residential aged care in Australia 2001-02: A statistical overview. Cat. no. AGE 29. Canberra, Australian Institute of Health and Welfare.

AIHW (2003b). Nursing labour force 2002, AIHW cat NO. HWL 29. Labour Force Series No 29. Canberra.

Angus, J. and R. Nay (2003): The paradox of the Aged Care Act 1997: the marginalisation of nursing discourse. *Nursing Inquiry* 10(2): 130-138.

Australian Department of Health and Ageing (2003). Clinical IT in aged care - Interim report. Canberra.

Australian Nursing Federation (2004). The national Aged Care Phone-In, Australian Nursing Federation.

Bowles, N. (1995): Story telling: A search for meaning within nursing practice. *Nurse Education Today*: 365-369.

Braithwaite, V., D. Gibson and J. Holman (1986): *Age Stereotyping: Are we over simplifying the phenomenon?* Baywood Publishing Co., Canberra.

Chater, K. (2002): Ageing:A body of resistance. *Nursing and Health Sciences* 4: 123-129.

Chen, S.-l., J. Witucki, P. Melcher and M. A. McKibben (2001): Use of nursing homes in Baccalaureate nursing education. *Nursing and Health Sciences* 3: 57-61.

Chilvers, J. R. and D. Jones (1997): The teaching nursing homes innovation: a literature review. *Journal of Advanced Nursing* 26(3): 463-469.

Commonwealth Department of Health and Ageing (2003). Resident Classification Scale Review: February 2003-No. 43. Canberra, Aged Care Evaluation and Management Advisors, Publications Production Unit.

Courtney, M. and V. Minichiello (1997): Aged care in Australia: a critical review of the reforms. *Journal of Ageing Studies* 11(3): 229.

Department of Education; Science and Training and Department of Health and Ageing (2002a). National Review of Nursing Education: Literature reviews. Canberra, Ausinfo.

Department of Education; Science and Training and Department of Health and Ageing (2002b). National Review of Nursing Education 2002: Our duty of care. Canberra, Ausinfo.

Edgar, D. (1991). Ageing - Everybody's future, Australian Institute of Family Studies**:** 14-19.

Edwards, H., H. Chapman, E. Forster, D. Gaskill, P. Morrison and F. Sanders (2003): Challenges associated with implementing an educational program in a residential aged care setting. *Australian Health Review* 26(3): 107-115.

Epston, D. and M. White (1992): Consulting your consultants:The documentation of alternative knowledges. In: D. Epston and M. White (ed.) *Experience, contradiction, narrative and imagination:Selected papers of David Epston & Michael White 1989-1991*, pp. 11-26. Dulwich Centre Publications, Adelaide.

Fassett, D. and M. R. Gallagher (1998): *Just a Head - Stories in a body*. Allen & Unwin, St. Leonards.

Giroux, H. (1988): Literacy and the pedagogy of voice and political empowerment. *Educational Theory* 38: 61-75.

Guba, E. G. and Y. S. Lincoln (1989): *Fourth Generation Evaluation*. Sage Publications, Newbury Park.

Happell, B. (2002): The role of nursing education in the perpetuation of inequality. *Nurse Education Today* 22: 632-640.

Happell, B. and J. Brooker (2001): Who will look after my grandmother? Attitudes of student nurses toward the care of older adults. *Journal of Gerontological Nursing* 27(12): 12-17.

Hayes, E. F. (2001): Factors that facilitate or hinder mentoring in the Nurse Practitioner Preceptor/Student relationship. *Clinical Excellence for Nurse Practitioners* 5(2): 111-118.

Healy, J. and S. Richardson (2003). Who cares for the elders? - What we can and can't know from existing data. Adelaide, National Institute of Labour Studies, Flinders University.

Herdman, E. (2002): Challenging the discourses of nursing ageism. *International Journal of Nursing Studies* 39: 105-114.

Hogan, W. P. (2004). Review of pricing arrangements in residential aged care. Canberra, Aged Care Price Review Taskforce, Commonwealth Department of Communications, Information Technology and the Arts.

Howard, G. (1991): Culture Tales:A narrative approach to thinking, cross-cultural psychology and psychotherapy. *American Psychologist* 46(3): 187-197.

Joy, J. P., D. E. Carter and L. N. Smith (2000): The evolving educational needs of nurses caring for the older adult: a literature review. *Journal of Advanced Nursing* 31(5): 1039-1045.

Katz, P., J. Karuza and S. Counsell (1995): Academics and the nursing home. *Clinics in Geriatric Medicine* 11: 762-770.

Kirkpatrick, M. K., S. F. Ford and B. P. Costello (1997): Story telling - An approach to client-centred care. *Nurse Educator* 22(2): 38-40.

Koch, T. and C. Webb (1996): The biomedical construction of ageing: Implications for nursing care of older people. *Journal of Advanced Nursing* 23: 954-959.

Lather, P. (1991): *Getting Smart - Feminist research and pedagogy with/in the postmodern*. Routledge, London.

Löfmark, A. and K. Wikblad (2001): Facilitating and obstructing factors for development of learning in clinical practice: a student perspective. *Journal of Advanced Nursing* 34(1): 43-50.

McGuiness, M. and Y. Wadsworth (1991): *Understanding anytime:A consumer evaluation of an acute psychiatric hospital*. Victorian Mental Illness Awareness Council, Melbourne.

Nay, R., S. Garratt and S. Koch (1999): Challenges for Australian nursing in the International Year of Older Persons. *Geriatric Nursing* 20: 14-17.

Nehls, N. (1995): Narrative pedagogy: Rethinking nursing education. *Journal of Nursing Education* 34(5): 204-210.

Nursing Board of Tasmania (2003). Guidelines for the Supervision of Students in the Practice Setting. Hobart, Tasmania, NBT**:** 1-4.

Pearson, A., R. Nay, S. Koch, C. Ward, C. Andrews and A. Tucker (2001). Australian aged care nursing: A review of education, training, recruitment and retention in residential

and community settings. National review of nursing education. Canberra, Commonwealth of Australia.

Queensland University of Technology (2004). Aged care core component in undergraduate nursing curricula: principles paper. Kelvin Grove, Queensland University of Technology, School of Nursing.

Richardson, S. and B. Martin (2004). The care of older Australians - a picture of the residential aged care workforce. Adelaide, National Institute of Labour Studies, Flinders University.

Robinson, A., K. Cubit, B. Francis, R. Bull, J. Crack and Y. Webber (2002). Making Connections in Aged Care:The report on the residential aged care preceptor project. Launceston, Tasmanian School of Nursing, University of Tasmania.

Robinson, A., K. Cubit, L. Venter and M. Fassett (2004). Building Connections in Aged Care: Developing support structures for student nurses on placement in residential care - Stage one report. Hobart, Tasmanian School of Nursing, University of Tasmania.

Robinson, A., F. McInerney, M. Sherring and A. Marlow (1999): Developing a collaborative preceptorship program involving registered nurses, student nurses and faculty. *Australian Journal of Advanced Nursing* 17(1): 13-21.

Smyth, J. and G. Shacklock (1998): Behind the 'cleansing' of socially critical accounts. In: G. Shacklock and J. Smyth (ed.) *Being reflexive in critical education and social research*, pp. 1-12. Falmer Press, London.

Stevens, J. and J. Herbert (1997). Ageism and nursing practice in Australia. Deakin, Royal College of Nursing, Australia.

Wade, S. (1999): Promoting quality of care for older people: developing positive attitudes to working with older people. *Journal of Nursing Management* 7: 339-347.

White, M. (1992a): Deconstruction and Therapy. In: D. Epston and M. White (ed.) *Experience, contradiction, narrative and imagination:Selected papers of David Epston & Michael White 1989-1991*, pp. 109-151. Dulwich Centre Publications, Adelaide.

White, M. (1992b): Family therapy training and supervision in a world of experience and narrative. In: D. Epston and M. White (ed.) *Experience, contradiction, narrative and imagination:Selected papers of David Epston & Michael White 1989-1991*, pp. 75-95. Dulwich Centre Publications, Adelaide.

Young, I. M. (1997): *Intersecting voices:Dilemmas of gender, political philosophy and policy*. New Jersey University Press, Princeton.